

***EAST PEORIA COMMUNITY HIGH SCHOOL  
DISTRICT #309***

***TAZEWELL MASON COUNTY SPECIAL  
EDUCATION ASSOCIATION***

**EMPLOYEE HEALTH AND  
DENTAL PLAN BOOKLET**

***JULY 1, 2005***

***EAST PEORIA COMMUNITY HIGH SCHOOL DISTRICT #309/TAZEWell  
MASON COUNTY SPECIAL EDUCATION ASSOCIATION  
EMPLOYEE HEALTH AND DENTAL PLAN BENEFITS***

The East Peoria Community High School District #309/Tazewell Mason County Special Education Association Employee Health and Dental Plan is primarily a self-funded Plan. The Employer and Association shall, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by each covered employee, if any, and any Plan revisions or modifications.

***RIGHTS TO RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY***

The Plan will pay charges incurred for an employee or dependent who is receiving benefits in connection with a mastectomy and then elects breast reconstruction in connection with the mastectomy. Coverage will include (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas. This coverage will be provided in consultation with the patient and patient's attending physician and will be subject to the same deductibles, coinsurance and/or co-pays otherwise applicable under the Plan.

***PLAN IS NOT A CONTRACT OF EMPLOYMENT***

The Plan will not be deemed to constitute a contract of employment or to give any participant the right to be retained in the service of the employer or to interfere with the right of the employer to discharge or otherwise terminate the employment of any participant.

***ANNUAL ROUTINE PHYSICALS***

The plan provides 100% coverage for an annual routine physical when performed by a PPO provider to a maximum benefit of \$300 each calendar year. Benefits available are further limited to coverage for participating employees and their covered spouses. No benefits are provided for non-PPO providers or covered dependent children.

**A routine physical examination is required for employees and covered spouses every two (2) years beginning in the calendar year the covered member reaches age thirty-five (35). Annual physicals are required beginning in the calendar year the covered member reaches age fifty (50). Failure to comply with either requirement will result in an additional \$300 deductible for all subsequent years until the year after the physical examination requirement is satisfied.**

***The Employer and Association intend to continue the Plan indefinitely, but reserve the right to amend or terminate the Plan in whole or in part, subject to negotiations, at any time. Such action may include, but not be limited to the type of benefit, deductible, copays, percentage payable, out-of-pocket maximums, maximum benefits, limitations and exclusions, and monthly contribution. Any such action will be communicated to participants in writing as soon as reasonably possible.***

## ***SCHEDULE OF MEDICAL BENEFITS TABLES***

The Schedule of Medical Benefits Tables is subject to the provisions of the Plan, including the determination that care and treatment is Medically Necessary and that charges are Reasonable and Customary. Take special note of the Pre-Certification Requirements, Medical Exclusions and Limitations, and Pre-Existing Condition Exclusionary Period.

	<b>PPO NETWORK</b>	<b>NON-PPO NETWORK</b>
Deductible	<b>Single \$300, Family \$900</b>	
Aggregate Annual Out of Pocket Maximum (including Deductible and Coinsurance)	<b>Single \$1,300 Family \$3,900</b>	<b>\$10,000 Per Person</b>
Lifetime Maximum Benefits	<b>\$1,000,000</b>	
<b>PREVENTIVE HEALTH SERVICES</b>		
Annual Routine Physical ( <i>maximum benefit of \$300 per calendar year for employees and their spouses only, see additional information under covered medical expenses section</i> )	<b>100%, No Deductible</b>	Not Covered
Routine Women's Health ( <i>1 annual exam/1 annual PAP</i> )	<b>100%, No Deductible</b>	80% After Deductible
Routine Prostate Exam ( <i>1 annually</i> )	<b>100%, No Deductible</b>	80% After Deductible
Routine Mammogram ( <i>see age guidelines/limitations</i> )	<b>100%, No Deductible</b>	80% After Deductible
<b>PHYSICIAN SERVICES</b>		
Physician Office Visits	<b>80% After Deductible</b>	60% After Deductible
Physician Surgical Procedures – Inpatient	<b>80% After Deductible</b>	60% After Deductible
Laboratory, Diagnostic & Surgical Office Services	<b>80%, No Deductible</b>	60%, No Deductible
Physician Surgical Procedures – Outpatient or in the Office	<b>80%, No Deductible</b>	60%, No Deductible
<b>INPATIENT HOSPITAL SERVICES</b>		
All Inpatient Services	<b>80%, No Deductible</b>	60% After Deductible
<b>OUTPATIENT HOSPITAL SERVICES</b>		
Outpatient Surgery & Observation	<b>80%, No Deductible</b>	60%, No Deductible
Outpatient Diagnostic X-ray and Laboratory Services	<b>80%, No Deductible</b>	60% After Deductible
<b>OTHER COVERED SERVICES</b>		
Emergency Care Hospital	<b>80%, No Deductible</b>	80% After Deductible
Genetic Testing	<b>80%, No Deductible</b>	60%, No Deductible
Home Health Care ( <i>80 visits combined</i> )	<b>80%, No Deductible</b>	60%, No Deductible
Organ Transplantation ( <i>Requires Prior Authorization</i> )	<b>80%, No Deductible</b>	60% After Deductible
Outpatient Rehabilitation ( <i>Physical, Occupational &amp; Speech Therapies</i> )	<b>80%, No Deductible</b>	60% After Deductible
Pathology Physician	<b>80%, No Deductible</b>	60%, No Deductible
Radiology Physician	<b>80%, No Deductible</b>	60%, No Deductible
Skilled Nursing Facility ( <i>81 days of care combined, limitations are per confinement</i> )	<b>80%, No Deductible</b>	60%, No Deductible

**PPO NETWORK    NON-PPO NETWORK**

Supplemental Accident Insurance ( <i>Up to \$300 combined</i> )	<b>100%, No Deductible</b>	100%, No Deductible
Ambulance Transportation	<b>80% After Deductible</b>	60% After Deductible
Anesthesia Physician	<b>80% After Deductible</b>	60% After Deductible
Chiropractic Care	<b>80% After Deductible</b>	60% After Deductible
Durable Medical Equipment & Prosthetic Devices ( <i>No Authorization Requirement</i> )	<b>80% After Deductible</b>	60% After Deductible
Emergency Care Physician	<b>80% After Deductible</b>	60% After Deductible
Radiation Therapy	<b>80% After Deductible</b>	60% After Deductible
Chemotherapy	<b>80% After Deductible</b>	60% After Deductible
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE</b>		
<b>Inpatient Services</b>		
Physician visits	<b>80% After Deductible</b>	60% After Deductible
Facility days	<b>80% After Deductible</b>	60% After Deductible
<b>Outpatient Services</b>		
Physician visits	<b>50% After Deductible</b>	50% After Deductible
Facility days	<b>50% After Deductible</b>	50% After Deductible
\$10,000 max each for physician & facility per person per lifetime for Substance Abuse Treatment \$1,000 max per person per year for facility & physician for Mental Health		

This section is a brief summary of the benefits contained in this plan. For complete information, refer to the Master Plan Document maintained by the Employer. If you have questions, contact the Claims Administrator at the number shown below.

**TO DETERMINE PPO PROVIDER STATUS:**

**OSF HealthPlans PPO Network & First Health PPO Network**

[www.osfhealthplans.com](http://www.osfhealthplans.com)

**Member Services Department: 866-694-1030**

## ***PRESCRIPTION DRUG CARD PROGRAM***

### **UP TO 30 DAY SUPPLY**

### **31 – 90 DAY SUPPLY**

Generic Drug Equivalents Insulin & Syringes	\$5		Generic Drug Equivalents Insulin & Syringes	\$10
Preferred Name Brand	\$10		Preferred Name Brand	\$20
Non-Preferred Name Brand	\$40		Non-Preferred Name Brand	\$80

#### ***Restriction on Refills:***

No benefits will be provided for prescription refills before the date on which 66% of the previous supply would have been consumed under the prescription’s schedule for consumption.

#### ***Exclusions:***

##### **No Prescription Drug Benefits Are Provided for the Products Listed Below:**

- Smoking deterrent medications.
- Anorexics, including but not limited to, amphetamines and non-amphetamines containing phenteramine or diethylpropin (drugs for weight loss).
- Any drugs used for cosmetic purposes.
- Any drugs labeled “Caution: Limited by Federal Law to Investigational Use” (or words to that effect), which OSF HealthPlans Inc. or Caremark Inc. determines are in a testing stage or in early field trials on animals or humans, or those drugs which do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed.
- Any charge for the administration of a Prescription Drug.
- Drugs, medications, vitamins or minerals that do not require a prescription.
- Devices and supplies (except insulin needles and syringes) of any type, including but not limited to therapeutic devices, artificial appliances, support garments, and blood glucose test meters.
- Immunization agents, biological sera, blood or blood plasma
- Total parenteral nutrition (TPN).
- Injectables, except for insulin or drugs dispensed by Caremark Specialty Pharmacy.
- Prescription Drugs which are not Medically Necessary.
- Replacement of lost or stolen Prescription Drugs.
- Prescription Drugs which are covered under another plan, any worker’s compensation or occupational disease law or any drug for which there is no charge to the Member.
- Prescription Drugs used in the treatment of infertility (covered by the Medical portion of the Plan).

For Questions regarding participating pharmacy status or mail-order pharmacy benefits call Caremark at (800) 966-5772

The Preferred Drug List can be accessed online at [www.osfhealthplans.com](http://www.osfhealthplans.com) – select “Member Services” and scroll down to the **2007 Preferred Drug List (also called Performance Drug List)**

## ***SCHEDULE OF DENTAL BENEFITS***

**There is no dental PPO network of providers. You may obtain services from a provider of your choice.**

### **CALENDAR YEAR DEDUCTIBLE**

Per Individual.....\$50

Per Family.....\$150

The deductible applies **only** to Class III Major Service expenses per calendar year for each Covered Person. If a family has satisfied the aggregate maximum family deductible during the same calendar year, no further deductible applies to any member of the family during the remaining calendar year. However, even if the employee and dependents are covered under the family coverage rules, no one individual is required to pay more than the individual calendar year deductible. These services **do not** apply to the medical deductible.

### **MAXIMUM BENEFIT**

Class I, II, and III services combined .....\$1,000 per individual per Calendar Year

Class IV services.....\$1,500 per Lifetime

**Note:** When a Covered Person has reached the calendar year maximum benefit, no further benefits for eligible dental care shall be owed or paid under this Plan and shall not be carried over and claimed for benefits in any subsequent calendar year.

### **PERCENTAGE PAYABLE**

The Plan will pay the percentage payable, as indicated, during a calendar year for the lesser of (1) the Reasonable and Customary charge for such services, or (2) the actual charge for such services.

<b>BENEFIT DESCRIPTION</b>	<b>DEDUCTIBLE APPLIES</b>	<b>PLAN PAYS</b>	<b>COMMENTS</b>
Class I – Preventive Services	No	100%	Subject to the calendar year maximum benefit.
Class II – Basic Services	No	80%	Subject to the calendar year maximum benefit.
Class III – Major Services	Yes	50%	Subject to the calendar year maximum benefit.
Class IV – Orthodontic Services	No	50%	Subject to \$1,500 maximum benefit per lifetime.

## ***PRE-CERTIFICATION/UTILIZATION REVIEW REQUIREMENTS***

The plan requires pre-certification of all hospital admissions. The utilization review service will determine whether the admission proposed by your physician can be certified as Medically Necessary. Failure to pre-certify an inpatient hospital admission will result in a reduction of benefits **BY THE ACUTAL BENEFITS AVAILABLE OR \$200 PER ADMISSION.**

**UTILIZATION REVIEW CERTIFICATION DOES NOT ASSURE THAT PROPOSED HOSPITAL ADMISSIONS ARE COVERED UNDER THE PLAN OR THAT THE PROVIDERS ARE PPO NETWORK PROVIDERS. PLEASE READ THE COVERAGE PROVISIONS CAREFULLY AND CHECK WITH THE PPO PROVIDER NETWORK TO ASSURE THEY ARE PPO PROVIDERS.**

## ***ELIGIBILITY***

### **EMPLOYEES ELIGIBLE FOR COVERAGE**

Employees eligible for coverage are as follows:

1. Full-time employees who are regularly scheduled to work an average of 32.5 hours or more per week in the employment of the employer, in the capacity that does not include acting as an independent contractor, contract worker, temporary, seasonal, or casual employee, or leased employee as interpreted by the employer using Internal Revenue standards.
2. State Mandate, Collective Bargaining Agreement, or Employer Personnel Policy

If coverage under the Plan would otherwise terminate with respect to a Covered Person due to a loss of active, full-time status, benefits will continue to be provided for those individuals to the extent required by law, a collective bargaining agreement in effect with respect to the Employer, or the Employer's personnel policy.

### **DEPENDENTS ELIGIBLE FOR COVERAGE**

**Note:** The Plan may require proof (such as a copy of the employee's income tax form, court order, legal adoption or legal guardianship papers) that the spouse or child qualifies as a dependent under the employee's coverage.

Dependents eligible for coverage are as follows:

#### **1. Spouse**

The employee's lawfully married wife or husband.

"*Marriage*" means one man and one woman in a lawful marriage contractually recognized by the State where the marriage was performed.

#### **2. Children**

The term *child* means an employee's natural child unless adopted by the step-parent, a stepchild, a legally adopted child, a child placed under the legal guardianship of the

employee, all of whom reside with the employee or have the employee's home as the chief place of residency; or a child for whose medical care an employee is legally responsible through a divorce decree or other court order.

A child will be covered from birth to the date on which the child reaches age 19 or to the date on which the child reaches age 23, if attending a vocational trade school, accredited high school, college or university on a full-time student basis, and provided:

- a. he is not married; and
- b. he is financially dependent upon the employee or spouse of the employee for principle support and maintenance. Requirement 2b will not apply to a child whose medical care is required due to a divorce decree or court order.

A previously ineligible dependent child who is less than 23 years of age, may be enrolled under the Plan as a new dependent within 31 days of the date of attendance as a full-time student. Proof of full-time student attendance from the registrar of the educational institution must be provided to the employer within this 31-day period. Coverage will be effective on the first of the month in which the semester begins.

Semester breaks (including summer) do not jeopardize a child's full-time status. However, if a child is not attending as a full-time student during the semester following the break, that child will no longer be considered a dependent under the Plan. Coverage will terminate on the first day of the semester following the break.

If cessation of full-time school attendance is due to graduation, coverage shall terminate at the expiration of the end of the calendar month following graduation.

### **3. Adopted Children**

Coverage for adopted children before the age of 18, who are enrolled within 31 days of the placement, begins on the date of placement for the purpose of adoption and is continued unless the placement is disrupted or discontinued prior to the legal adoption of the child. If disruption or discontinuation occurs, coverage will cease on the date the child is no longer in the custody of the employee. All rules apply under #2, "Children" above.

### **4. Qualified Medical Child Support Order (QMCSO)**

Any eligible child covered by a Qualified Medical Child Support Order (QMCSO) is required to be covered under the Plan as of the date of the QMCSO or coinciding with the employee's effective date of coverage, whichever is later. If the employee is not enrolled for dependent coverage, the employee and dependents must be enrolled in the Plan and the employee must pay any required contribution for family coverage. If the coverage is for a stepchild, and the parent named in the QMCSO is covered under the stepparent's health plan, the Plan must enroll that stepchild. All rules apply under #2, "Children" above.

Upon receipt of a Qualified Medical Child Support Order (QMCSO), the employer: (a) will notify the employee and alternate recipient (i.e. the child or the child's representative) of the Plan's receipt of the order and the Plan's procedures for determining whether the order is qualified; (b) will determine whether the order is qualified within a reasonable period; (c) will notify the employee and each alternative recipient of the determination; and (d) if the order is qualified, will administer the provision of benefits under such orders.

Your employer has the ultimate authority to determine whether or not the order meets all of the requirements. If the order does not meet all of the qualification requirements, the Plan need not provide any benefits to the alternate recipient unless the deficiencies are later corrected by the parties.

#### **5. Developmentally or Physically Disabled Child**

A developmentally or physically disabled child's coverage may be extended beyond age 19 if the child is incapable of earning a living and self-sustaining employment and dependent upon the employee for financial support and maintenance.

A letter of proof of incapacity and dependency from the parents and the attending physician is required within 31 days of the dependent's attainment of age 19, or 23 in case of a full-time student. The Plan may require that a physician examine the child before granting a continuation of coverage and will pay all costs in connection with the examination.

This provision stops on the earliest of the following dates:

- a. the date the child is no longer disabled according to the Plan; or
- b. the date the Plan is not furnished with proof of the child's disability when requested.

#### **Those situations specifically excluded from the definition of a dependent are:**

1. A spouse who is legally separated or divorced from the employee.
2. If both husband and wife are eligible as employees, only one may carry dependent coverage.
3. Any person eligible under the Plan may be covered as an employee or as a dependent, but not as both.

### **ENROLLMENT REQUIREMENTS**

Employees who complete and submit an enrollment form and any additional forms required by the employer within 31 days of their date of hire are considered timely entrants.

Employees who do not enroll themselves or their eligible dependents within 31 days of their date of hire, or the date they are initially eligible for coverage under the Plan will be considered late entrants.

### **LATE ENTRANTS**

If an employee or eligible dependent is considered a late entrant, proof of good health will be required before coverage can become effective under the plan.

The employee or eligible dependent must submit at his own expense, evidence of his good health which is satisfactory to the Employer and Claim Administrator. His eligibility date will be the date of approval by the employer and Claims Administrator of the evidence of his good health. An employee whose coverage is approved in this manner will be subject to the limitation on pre-existing conditions.

#### ***PRE-EXISTING CONDITION EXCLUSION***

Employees and Dependents who are considered Late Entrants will be subject to a Pre-Existing Condition exclusionary period. No benefits will be paid for a Pre-Existing Condition until the earlier of:

1. Employees – 6 months from the date coverage commenced under the Plan; or

2. Dependents – 12 months from the date coverage commenced under the Plan; or
3. All Covered Persons – the day following a 3 month period, measured from the date coverage commenced under the Plan, for which no expenses incurred or for which medical advice, diagnosis, care, or treatment was recommended or received with respect to the Pre-Existing Condition.

The pre-existing condition exclusion does not apply to:

1. Covered Persons continuously covered under the Plan since the effective date.
2. Employees and Dependents enrolled within 31 days of the Employees date of hire or initial eligibility.
3. A newborn child or newly adopted child under age 18 if the child is covered within 31 days of the date of birth, adoption, or placement for adoption.

### **WAIVER OF COVERAGE**

Employees who elect not to enroll themselves and/or their dependents must complete a waiver of coverage form. The waiver of coverage must be submitted to the employer within 31 days of meeting the Plan's eligibility requirements.

### **EMPLOYEE'S EFFECTIVE DATE OF COVERAGE**

You will be covered provided you meet eligibility and waiting period requirements as listed, and provided any required contributions are made.

1. Full-time employees will be effective on the date they are eligible.
2. Employees who have an employment status change will be effective on the date they are considered full time employees.
3. Full-time employees who enroll as late entrants on the date they are approved for coverage by their employer or the claim administrator.

### **DEPENDENT'S EFFECTIVE DATE OF COVERAGE**

Dependent coverage will not take effect unless the employee's coverage is in effect and any required contributions are made. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Eligible dependents become covered as follows:

1. If the dependent is enrolled as a dependent on the employee's effective date, the dependent becomes covered under the Plan on the date of the employee's effective date.
2. If the dependent becomes an eligible dependent after the employee's effective date, the dependent becomes eligible to be enrolled under the Plan as specified in the special enrollment periods provision.
3. If a dependent is enrolled due to a court order including a Qualified Medical Child Support Order (QMCSO), coverage will become effective on the date of the court order or coinciding with the effective date of the employee's coverage, whichever is later.

When a dependent has met one (1) of the eligibility requirements above, the employee must complete and submit an enrollment form and any additional forms required by the employer within 31 days of the initial date of the dependent's eligibility. If the employee fails to enroll within 31 days of the initial date of the dependent's eligibility, that dependent will be considered a late entrant.

The following rules apply for coverage of **newborn children** from the moment of birth:

A newborn child will be covered automatically from the date of birth, provided you complete and submit all necessary forms adding the newborn child, changing to family coverage, if necessary, within the first 31 days of the child's date of birth and agree to pay the required contribution (if any) for family coverage.

**Note:** Charges for a baby will be subject to the newborn's own deductible and out-of-pocket maximum.

#### **EMPLOYEE TERMINATION OF COVERAGE**

Subject to Continuation of Coverage (COBRA), FMLA leave, and certain leaves of absence, the coverage of any employee will automatically **terminate at midnight** on the earliest date indicated below:

1. On the date of the month in which employment ends.
2. On the date in which the employee ceases to qualify as an employee.
3. On the date any required contribution for coverage is not made, unless due to a clerical error whereby past contributions may be paid to bring coverage current.
4. On the date the Plan is terminated with respect to all employees, or on the date a benefit provided under the Plan is terminated.
5. On the date in which an employee retires, unless he meets the definition of an eligible retiree.
6. On the date the employee becomes an active full-time member of the armed forces of any country.
7. On the date of the employee's death.
8. On the date of the month in which the employee elects to terminate coverage.

#### **DEPENDENT TERMINATION OF COVERAGE**

Subject to Continuation of Coverage (COBRA), FMLA leave and certain leaves of absence, dependents' coverage will automatically **terminate at midnight** on the earliest date indicated below:

1. On the date the employee's coverage terminates.
2. On the date the required contribution for dependent coverage is not made, unless due to a clerical error whereby past contributions may be paid to bring coverage current.
3. On the date the Plan is terminated with respect to all dependents or on the date a dependent benefit provided under the Plan is terminated.
4. On the date in which such dependent ceases to be a dependent of the employee as defined herein.
5. On the date the dependent becomes an active full-time member of the armed forces of any country.
6. On the date in which the employee elects to terminate the dependent's coverage.
7. On the date the dependent becomes effective as an employee under the Plan.

## **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

If an eligible employee ceases work due to an employer approved FMLA leave in accordance with the requirements of Public Law 103-3, coverage will be continued for a period not to exceed 12 weeks within a 12 consecutive month period under the same terms and conditions which would have been provided had the employee continued work, and provided the employee continues to pay any required contributions. Contributions will remain at the same employer/employee percentage level as on the date immediately prior to the leave (unless contributions change for other covered employees in the same classifications).

If the employee does not return to work after the approved family or medical leave or if the employee has given the employer notice of intent not to return to service during the leave, coverage may be continued under the Continuation of Coverage (COBRA) provision of the Plan effective with the date notification is given to the employer and provided the employee elects to continue coverage under the COBRA provision. The employee will be totally responsible for the contributions during the COBRA continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum COBRA continuation period.

Coverage will be reinstated (for those employees and their dependents who were covered when the leave began) on the date the employee returns to work without re-satisfying any waiting period. Pre-existing condition exclusion will apply only to the extent it may have applied on the date coverage terminated. The employee must make any necessary contributions and payroll authorizations within 31 days of the return to work for coverage to be reinstated.

*Eligible employee* is an employee who has worked for the employer: (1) at least 12 months and (2) for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave and (3) at a work site where the eligible employer employs at least 50 employees within a 75 mile radius.

*Eligible employer* means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar work weeks in a current or preceding calendar year.

For additional details regarding this section, refer to your employer's latest policy announcement on leaves of absence.

It is the intent of the Plan to comply with all existing FMLA regulations. If for some reason the information presented in the Plan differs from actual FMLA regulations, the Plan reserves the right to administer FMLA in accordance with such actual regulations.

## **ACTIVE MILITARY DUTY AND MILITARY RESERVISTS**

If coverage terminates due to an employee or covered dependent being called to active military duty, there is no extension of benefits except what is chosen through the Continuation of Coverage (COBRA) election.

Employees and/or their eligible dependents returning to work within the first full business day following completion of their military service for a leave of 30 days or less; within 14 days of completing their military service for a leave of 31 to 180 days; or within 90 days of completing their military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an illness or injury determined by the VA to be service connected will be allowed) may have reinstatement of immediate coverage, provided such person was covered under the Plan as of

the date he was called to active duty in the armed forces. The coverage provided will be the benefits currently provided by the Plan. The waiting period and pre-existing condition exclusionary period will be credited. If he returns within the same calendar year, credit will be given for eligible charges accumulated toward the satisfaction of provisions such as the out-of-pocket and deductible or calendar year maximums when determining benefits available for the remainder of the calendar year.

It is the intent of the Plan to comply with all existing regulations of The Uniformed Services Employment and Reemployment Rights Act (U.S.E.R.R.A.) of 1993. If for some reason the information presented in the Plan differs from the actual regulations of the U.S.E.R.R.A., the Plan reserves the right to administer the U.S.E.R.R.A. in accordance with such actual regulations.

### **EXTENSION OF BENEFITS DUE TO DISABILITY**

If coverage terminates due to total disability, there is no extension of benefits except what is chosen through the COBRA or FMLA election.

### **OPTIONAL CONTINUATION OF COVERAGE**

This Plan offers continuation of coverage in a manner consistent with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Please contact the Claim Administrator for questions regarding optional continuation of coverage.

## **GENERAL PROVISIONS**

### **COORDINATION OF BENEFITS (COB)**

This Plan elects to comply with the NAIC (National Association of Insurance Commissioners) model coordination of benefits regulations as adopted by the State of Illinois. A summary of the model rules are described below. This Plan will automatically comply with any changes to the NAIC model coordination of benefit regulations as of the date they are adopted by the State of Illinois.

### **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

The claims administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the plan administrator or claims administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the plan administrator or claims administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the plan administrator or claims administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the plan sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as plan administrator as determined pursuant to the reasonable exercise of discretion of the plan administrator.

In addition, the plan sponsor hereby certifies and agrees that it will:

1. Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
2. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
3. Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;
4. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
5. Report to the appropriate representative of the plan administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make available protected health information in accordance with 45 C.F.R. 164.524;
7. Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

8. Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;
9. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;
10. If feasible, return or destroy all protected health information received from the Plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
11. Ensure that the adequate separation between the Plan and the plan sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq.* Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the plan administrator.

### **SUBROGATION/THIRD PARTY LIABILITY**

In the event of your or your dependent's Illness or Injury occurring by reason of the act or omission of another person for which there exists legal liability, the Plan shall have the right to reduce benefits otherwise payable by the Plan (subrogation) or to recover benefits previously paid by the Plan (reimbursement). These rights shall apply to the full extent of any and all recoveries or payments resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers, regardless of whether or not the recovery or payment is designated as payment for or allocable to medical expenses. The Plan's rights of subrogation and reimbursement apply to any recoveries which you realize. The Plan's rights will not be reduced due to your own negligence.

The Plan has a first priority to receive payment on any claim against a third party before you receive payment from that third party. You must assign to the Plan all rights of recovery against third parties to the extent of benefits the Plan has provided for an Illness or Injury caused by a third party. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized, including, but are not limited to economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (*i.e.*, fully compensated for your injuries and damages). **CAUTION: You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.**

You must cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- complying with the terms of this Subrogation/Third Party Liability Section;
- providing any relevant information requested;
- signing and/or delivering documents at the Plan's request;
- appearing at medical examinations and legal proceedings, such as depositions or hearings; and
- obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

If you fail to cooperate with the Plan or its agents, the Plan Administrator has the authority to terminate Your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of the benefits the Plan has paid relating to any Illness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a illness or injury caused by a third party. In the event of your death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs. If a third party causes you to suffer an illness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a covered person.

## **APPEALS PROCEDURES**

You will use the Appeal procedure if you wish to appeal a denial or partial denial of any claim for benefits, including, but not limited to:

1. Claims Involving urgent care.
2. Claims involving an ongoing course of treatment, which include a request to extend the ongoing course of treatment beyond the period of time or number of treatments previously approved. Also included in this category are claims opposing the reduction or termination of the course of treatment before the end of the period of time or number of treatments previously approved.
3. Pre-service claims, which include claims for services, procedures, or treatments you are seeking and have not yet received, such as claims for specific tests or procedures, claims for referral to a specialty care physician, and claims for denial of hospitalization requests.
4. Post-service claims, which include claims for payment for procedures or treatments already provided.

### **HOW TO FILE AN APPEAL:**

Appeals may be made to OSFHP either orally or in written form. Appeals may be made orally by calling OSFHP Customer Service Department as follows:

Telephone:	(309) 677-8222
Toll-free Telephone:	(866) 694-1030
TDD/TDY:	(800) 874-9426

Written Appeals should be mailed to the following address:

OSF Health Plans, Inc.  
P.O. Box 1229  
Peoria, IL 61654-1229

Appeals are not considered to have been filed until submitted to and received by OSFHP in one of these ways.

### **TIME FOR FILING AN APPEAL**

#### **1. Standard Appeals**

All Appeals must be filed with OSFHP within 180 days from the date of receipt of any adverse benefit determination which pertains to the incident in question. Appeals that do not meet this deadline will be denied.

#### **2. Expedited Appeals**

You may request that any claim involving urgent care or any claim involving an ongoing course of treatment be handled on an expedited basis. *Expedited Appeals must be filed within 12 hours after you receive notice of the adverse benefit determination.* An Appeal otherwise eligible for handling as an expedited appeal that is filed more than 12 hours after receipt of the adverse benefit determination will be treated as a Standard Appeal. You may also ask that your request be treated as a new claim for benefits, in which case the time periods applicable to deciding claims for benefits starts to run again.

### **DETERMINATION OF STATUS AS AN EXPEDITED APPEAL**

There are two types of Appeals: expedited appeals and standard appeals. You may request that your Appeal be conducted as an expedited appeal if it concerns a claim involving urgent care or a decision to reduce or terminate an ongoing course of treatment. Your request may be presented to OSFHP either orally or in writing.

If you indicate that you are requesting an expedited appeal, appropriate health care professionals at OSFHP will determine whether your request meets the criteria for an expedited appeal and will notify you, your physician, and any provider who recommended an ongoing course of treatment of this determination.

If a physician with knowledge of your medical condition determines that your claim is a claim involving urgent care, your claim will be treated as such and an Appeal from a denial of the claim is eligible for handling as an expedited appeal. If the criteria for an expedited appeal are not met, your Appeal will be conducted as a standard appeal.

### **CONTENTS OF YOUR APPEAL**

There are no required forms for you to fill out to file an Appeal. However, at a minimum your Appeal must contain your name, current address, current telephone number, Member identification number, and a detailed description of the decision, determination, or action which

is being appealed, the remedy sought, and the basis for the Appeal. If your Appeal is filed orally, an OSFHP representative will assist you in furnishing the necessary information. At your option, you may contact OSFHP at the telephone numbers given above to request an Appeal form, which you may fill out and return.

### **WHO MAY FILE AN APPEAL**

1. You may file an Appeal.
2. Your legal guardian or other legal representative may file an Appeal.
3. You may designate a personal representative (including your physician or any health care professional) to act as your representative to file the Appeal for you by submitting a completed and executed Personal Representative affidavit and a completed and executed Protected Health Information Authorization to OSFHP Customer Services. These forms are available on request from OSFHP Customer Services. If you designate a personal representative, all subsequent communications and notices from OSFHP will be sent to your personal representative and not to you.

### **APPEALS INVOLVING DETERMINATIONS OF ELIGIBILITY**

If OSFHP determines that an Appeal involves a decision as to whether or not an individual is eligible to participate in or be covered for benefits under the Plan, OSFHP will refer that aspect of the Appeal to the plan administrator for a decision. In such a case, the Plan Administrator will be bound to the same requirements and procedures that otherwise apply to OSFHP.

### **YOUR RIGHT TO SUBMIT SUPPORT FOR YOUR APPEAL**

You have the opportunity to submit written comments, documents, records, and other information in support of your Appeal either in person or in writing. In this regard, OSFHP will attempt to gather all necessary medical information relevant to your Appeal. However, it may be helpful to include additional information to clarify or support your request. For example, you may want to submit in support of your Appeal information such as medical records or physician opinions. To obtain medical records, you may send a written request to your physicians or providers. You will need to make a separate request to each physician(s) or provider(s).

In the case of an expedited appeal, you or your authorized representative may submit such information in person, by telephone, or in writing transmitted by FAX at the address and telephone number referenced above in the How to File an Appeal or Complaint Section. Please call OSFHP Customer Services for additional information on the procedures for submitting evidence and support for your Appeal.

### **YOUR RIGHT TO ACCESS TO RELEVANT INFORMATION**

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information “relevant” to your claim for benefits. A document, record, or other information is “relevant” if it:

1. Was relied upon in making the adverse benefit determination;
2. Was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether it was relied upon in making the determination;
3. Demonstrates compliance with the administrative processes and safeguards required by law; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

“Relevant” information generally includes your medical records relating to the benefit claim. However, if OSFHP has reason to believe that your medical records contain information that should be explained or disclosed by the physician who developed the information, OSFHP may refer you to that physician for such information prior to providing the requested documents directly to you. If the physician fails to provide the information to you within a reasonable period of time and without charge, OSFHP will then provide it directly to you.

OSFHP has no obligation to create or develop new documents in order to comply with a request made by you for “relevant” information. Furthermore, OSFHP will not disclose other persons’ individual records or information specific to the resolution of claims of other persons.

You may also request the identification of medical or vocational experts whose advice was obtained by OSFHP in connection with the adverse benefit determination of your claim without regard to whether the advice was relied upon in making the adverse benefit determination.

#### **HOW YOUR APPEAL WILL BE CONDUCTED**

After receiving your request for an Appeal, the appropriate OSFHP personnel will conduct your Appeal in accordance with the following criteria:

1. You will be notified within 24 hours in an expedited appeal and within 3 business days in a standard appeal of any additional information required by OSFHP to evaluate your Appeal. It then becomes your responsibility to furnish the requested information to OSFHP. If you do not submit the requested information, OSFHP will decide your Appeal on the basis of the information it has and within the time periods listed below.
2. The reviewer on appeal will consider the full record of the claim and will not afford deference to the initial adverse benefit determination. The reviewer will take into account all comments, documents, records, and other information submitted by you or on your behalf relating to the claim without regard to whether such information was submitted or considered in the initial adverse benefit determination.
3. The reviewer will not be the individual who made the initial adverse benefit determination nor the subordinate of such individual.
4. In deciding an Appeal that is 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, investigational, or not Medically Necessary or appropriate, the reviewer will be a physician and, unless the reviewer is a clinical peer, will consult with a clinical

peer who has appropriate training and experience in the field of medicine involved in the medical judgment. A clinical peer consulted in connection with the Appeal will not be the same individual who was consulted in connection with the initial adverse benefit determination nor the subordinate of such individual.

5. In conducting an expedited appeal, all necessary information, including OSFHP's final benefit determination on review, shall be transmitted between OSFHP and you by telephone, facsimile, or other available similarly expeditious method.

#### **TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**

OSFHP will complete the Appeal and give notice of its benefit determination on review within the following time periods:

1. Claims involving urgent care—as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt by OSFHP of the request for Appeal.
2. Claims involving an ongoing course of treatment (handled as an expedited appeal)—as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt by OSFHP of the request for Appeal.
3. Pre-service claims—within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt by OSFHP of the request for Appeal.
4. Post-service claims—within a reasonable period of time, but not later than 60 days after receipt by OSFHP of the request for Appeal.

#### **NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**

OSFHP shall notify the following parties of its decision by written or electronic notice of the benefit determination: You; the party filing the Appeal; your primary care physician; any provider who recommended the health care services involved in the Appeal. You have the right to request, and receive free of charge, a paper copy of each document sent by electronic means, including a copy of the benefit determination on review.

#### **CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**

The notification of benefit determination on Appeal will contain the final decision of OSFHP regarding your Appeal. The decision may be favorable to you or adverse, in whole or in part. If the decision is adverse, in whole or in part, the notification of benefit determination on review will contain all of the following information:

1. The specific reason or reasons for the adverse determination.
2. A reference to the specific Plan provisions on which the determination is based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

4. Any specific rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination on Appeal, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and that a copy will be provided to you free of charge upon request.
5. If the adverse benefit determination on Appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.
6. Other statements as may be required applicable law.

***THE DECISION UPON REVIEW WILL BE FINAL. IT SHALL BE IN WRITING AND CONTAIN THE SPECIFIC REASON(S) FOR THE DECISION, CONTAIN REFERENCES TO THE PERTINENT PLAN LANGUAGE UPON WHICH THE DECISION WAS BASED, AND BE WRITTEN IN A MANNER TO BE UNDERSTOOD BY THE EMPLOYEE.***

## ***PLAN INFORMATION***

1. Name of Plan:  
**East Peoria Community High School District #309/Tazewell Mason County Special Education Association Employee Health and Dental Plan.**
  
2. Name and address of employer whose employees are covered by the Plan:  
**East Peoria Community High School District #309/Tazewell Mason County Special Education Association  
1401 E. Washington  
East Peoria, IL 61611 (309) 694-8307**
  
3. Type of Plan:  
**Medical (health), Dental, and Prescription Drug Program.**  
Source of contributions to the Plan:  
**East Peoria Community High School District #309/Tazewell Mason County Special Education Association and its employees contribute to the cost of the Plan.**
  
4. Date of the end of the Plan Year:  
**Plan years end on each June 30th. Financial records of the Plan are kept on a Plan Year basis.**
  
5. Plan Administrator/Plan Sponsor:  
**East Peoria Community High School District #309/Tazewell Mason County Special Education Association  
1401 E. Washington  
East Peoria, IL 61611 (309) 694-8307**
  
6. Agent for service of legal process:  
**David N. Schellenberg  
Elias, Meghinnes, Riffle & Seghetti, P.C.  
416 Main Street, Suite 1400  
Peoria, IL 61602  
(309) 637-6000**  
  
**Service of legal process may also be made upon the Plan Administrator/Plan Sponsor.**
  
7. Claims Administrator & Utilization Review Administrator:  
**OSF HealthPlans  
7915 N. Hale Avenue, Suite D  
Peoria, IL 61615  
(309)677-8200**