



January 1, 2018

**Medical and Prescription
Benefits Booklet
For Active Employees
and their Dependents**

SCHOOL EMPLOYEES' BENEFIT TRUST (SEBT) HEALTH BENEFIT PLAN

This booklet describes the Medical Benefits for Eligible Employees of the School Employees' Benefit Trust (SEBT).

The following phone numbers and websites are listed below for your convenience. They are also on your ID card, or referenced within the body of this document.

- ◆ For pre-certification call (1-866-458-2995)
- ◆ For network providers in Aetna Signature Administrators Network: (1-866-455-8727) or www.alliedbenefit.com
- ◆ For questions about prescription drug card call (866) 275-0044 or visit www.express-scripts.com
- ◆ For questions about claims, benefits or eligibility, call Allied Benefit Systems, Inc. (1-866-455-8727) or www.alliedbenefit.com
- ◆ For questions to the Chief Administrator (phone 1-614-873-6398) or e-mail to: eshafley@planmanagementservice.com

The benefits in this booklet are effective January 1, 2018

SEBT

SCHOOL EMPLOYEES' BENEFIT TRUST

January 2018

To: All Participants in the SEBT Health Plan
From: Brad Yates, SEBT Chairman

Subject: SUMMARY PLAN DESCRIPTION

This booklet describes the current benefits provided by the School Employee's Benefit Trust (SEBT) health plan. It is available at this time, in large part, due to the combined efforts of many individuals, including:

Staff of Allied Benefit Systems, Inc., SEBT Third Party Administrator

Elaine Shafley, SEBT Plan Manager

Mark Burry, SEBT Legal Counsel

Members of the SEBT Board of Trustees

Our mission is to provide our members with an effective and efficient health plan that is competitive in today's ever-changing climate. We believe that the continued offering of our Network Deductible Plan and the Consumer Driven Health Plans, meets that objective. All plans now utilize the Aetna Signature Administrators Network to provide Preferred Provider Organization (PPO) quality and savings. The plans continue to reflect the Board of Trustees' on-going efforts to maintain quality benefits while being sensitive to increases in premiums.

I encourage you to familiarize yourself with the benefits offered and your responsibilities to enable you to use the plan you selected, as effectively as possible. Please contact the applicable SEBT representative to assist you with any concerns or questions.

We are pleased to provide you with this booklet, and trust that it will assist you in managing your health care plan.

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KEY INFORMATION

EMPLOYER/COMPANY/PLAN ADMINISTRATOR/ PLAN SPONSOR CONTACT INFORMATION:

School Employees' Benefit Trust
805 East Harrison St.
Bluffton, IN 46714

PLAN BOOK EFFECTIVE DATE:

January 1, 2018

PLAN YEAR:

The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends each December 31st.

TYPE OF PLAN:

Medical and Prescription Drugs

NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:

Allied Benefit Systems, Inc.
P. O. Box 909786-60690
Chicago, IL 60690
Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

PRIVACY OFFICERS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- a. The following persons under control of the Plan Sponsor shall be given access to the PHI: Chief Administrator, and all other staff designated by the Chief Administrator.
- b. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan's Privacy Officer shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs.

IMPORTANT NETWORK CONTACT INFORMATION:

Function	Network Name	Claims Filing Information	Phone Number	URL
PPO Network	Aetna Signature Administrators	Electronic Emdeon Payer: #37308 Paper: Allied Benefit Systems, Inc. P.O. Box 909786-60690 Chicago, IL 60690	(866) 455-8727	www.alliedbenefit.com

To Eligible Employees of School Employees' Benefit Trust:

Please take time to read this information before you or one of your Dependents become ill or injured. Understand your benefits, use them wisely and make every dollar count.

You are offered the opportunity to enroll in the "Network Deductible Plan" (which has a Network Deductible on many services), or the "Consumer Driven Health Plans A, B or C" (which means the deductible must be met first before plan benefits are available on most services)– see pages 14-24.

The Plans contain a PPO (Preferred Provider Organization) and generally pay higher benefits if you use a provider that is in the PPO network. The name of the PPO along with the address where all medical claims must be filed is shown on your ID card. An "Explanation of PPO Options" and a "Schedule of Covered Services" (showing coverage and payment levels under the plan) are shown on the following pages.

As you review the Schedule of Covered Services, it is important that you keep in mind that all Out of Network Providers for your Plan, are subject to Reasonable and Customary Charge limitations. This means that the maximum allowable amount for all Out of Network services is based on the definition of "Reasonable and Customary" (see page 45). Normally, the Plan's payment will be a percentage of that amount (see "Schedule of Covered Services"). However, in any case where the provider's total charge exceeds the Reasonable and Customary charge, the excess amount is not eligible under the Plan, although the provider is free to balance bill the patient since no contract provisions prevent this course of action.

On the other hand, if the Covered Person utilizes an In-Network provider, the maximum allowable amount is based on a contracted fee schedule. Therefore, any amount of the provider's bill over the maximum amount allowed by the Plan is not subject to balance billing by the provider in these cases.

PRE-CERTIFICATION REQUIREMENT: The Plans also include a **Pre-Certification Program**. Either the Covered Person

or the treating Physician must contact Utilization Review (using the number as shown on the back of your ID card, or through fax or e-mail). **Failure to follow the guidelines below and on the next page will subject your benefits to the “Penalty for Non-Compliance” shown in the Schedule of Covered Services.**

Pre-Certification is required for the following services:

1. All home health care services, including home uterine monitoring.
2. Artificial intervertebral disc surgery.
3. Dental implants and oral appliances.
4. Elective (non-emergent) transportation by ambulance or medical van, and all transfers via air ambulance.
5. Inpatient Confinements:
 - a. Surgical and non-surgical, excluding vaginal or Caesarean deliveries.
 - b. Skilled nursing facility.
 - c. Rehabilitation facility.
 - d. Inpatient hospice (except Medicare).
6. Lumbar spinal fusion surgery.
7. Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint.
8. Reconstructive procedures that may be considered cosmetic:
 - a. Blepharoplasty/canthopexy/canthoplasty.
 - b. Excision of excessive skin due to weight loss.
 - c. Rhinoplasty/rhytidectomy.
 - d. Gastroplasty/gastric bypass.
 - e. Pectus excavatum repair.
 - f. Breast reconstruction/breast enlargement.
 - g. Breast reduction/mammoplasty.
 - h. Surgical treatment of gynecomastia.
 - i. Lipectomy or excess fat removal.
 - j. Sclerotherapy or surgery for varicose veins.
9. Selected durable medical equipment:
 - a. Electric or motorized wheelchairs and scooters.
 - b. Clinitron and electric beds.
 - c. Limb prosthetics.
 - d. Customized braces.
10. The following conditionally eligible services:
 - a. Stereotactic radiosurgery.
 - b. Somatosensory evoked potential studies.
 - c. Cognitive skills development.
 - d. Hyperbaric oxygen therapy.
 - e. Osteochondral allograft/knee.

- f. Cochlear device and/or implantation.
 - g. Osseointegrated implant.
 - h. Percutaneous implant of neuroelectrode array, epidural.
 - i. GI tract imaging through capsule endoscopy.
 - j. Botox injections -- botulinum toxin type
 - k. Alpha 1-proteinase inhibitor – human.
 - l. Negative pressure wound therapy pump.
 - m. High-frequency chest wall oscillation generator system.
11. Uvulopalatopharyngoplasty, including laser-assisted procedures.

If Your Physician recommends an Inpatient confinement or any of the services listed above, please follow these steps:

1. Notify your Physician that you participate in a Pre-Certification Program. Please note that this applies even if this Plan is secondary under Coordination of Benefits.
2. You or your Physician must contact Utilization Review at least one business day prior to all non-emergency Inpatient Hospital admissions. If you have an emergency admission, contact must take place within two business days of admission.

The following information will be needed to pre-certify:

Regarding Patient:

Name
 Address
 Telephone #
 Date of Birth
 Relationship to Employee
 Physician's Name
 Physician's Phone Number
 Hospital/Address

Regarding Employee:

Name
 Address
 Telephone #
 Date of Birth
 Sex
 Social Security Number
 Name of Employer
 Name of Plan Supervisor
 (Allied Benefit Systems, Inc.)

3. A nurse will call your Physician to review a proposed Hospital admission. If Hospitalization is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.
4. When you or your Physician contact Utilization Review to pre-certify a Hospital admission, the contact will be logged so that:
 - The hospital can verify that pre-certification has been done and can track expected length of stay.
 - The Plan Supervisor can verify that the pre-certification requirements have been met when the claim is received for processing.

Note: Pre-Certification of Hospital admissions assists in determining medical necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

PENALTY FOR NON-COMPLIANCE

The **non-compliance penalty*** regarding services that require Pre-certification specified in the “Schedule of Covered Expenses” will apply under one or more of the following circumstances: a) pre-certification call is not made according to the instructions on page 7; b) Hospital stay exceeds the amount of days pre-certified; c) patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

*This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the “Schedule of Covered Services”. The penalty will be applied to Covered Services that were incurred during the days that were not pre-certified.

CASE MANAGEMENT OPTION

Case Management is a program whereby, in certain catastrophic or long-term medical conditions, a case manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- ◆ Personal support to the patient;
- ◆ Contacting the family to offer assistance and support;
- ◆ Monitoring care
- ◆ Determining alternative care options; and
- ◆ Assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. The alternate benefit must be beneficial to both the patient and the Plan. **Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.**

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Note that each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Note: The term Case Management shall also apply to those situations where the Plan approves an alternate level of benefits for Outpatient visits in lieu of Inpatient hospitalization at the request of the patient's Physician.

STATEMENT OF RIGHTS FOR NEWBORNS AND MOTHERS

The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The Plan will not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Further, the Plan will not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

WELLNESS VS. RISK FACTORS

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

USING YOUR MEDICAL ID CARD

Please be aware that you will be issued a single ID card to obtain medical benefits. This ID card, issued by Allied Benefit Systems, Inc. (“Allied”), the Plan Supervisor has all the identifying information that your medical provider needs to verify your eligibility for medical coverage.

Note that the front of the card identifies the name and number of your group (School Employees’ Benefit Trust – Group # A01216) along with the Employee’s name and identification number. All family members are referenced under the employee’s identification so that every family member can use an identical card. However, the name, identifying information and claims history for each family member is also retained on Allied’s eligibility and claims processing system. Therefore, providers and Covered Persons can verify coverage or check claims status for any family member by calling Allied’s toll-free number shown on the back of the card.

Note that the front of your card has the logo/name and claims filing information unique to the PPO (Preferred Provider Organization) that the Plan utilizes, along with the phone number and website for that organization.

The back of the ID card shows the toll-free number you must call for pre-certification of all elective Inpatient Hospital admissions/ notification of all emergency Inpatient Hospital admissions. Failure to follow these requirements will result in the benefit reductions or penalty shown on the following pages.

Note also that the Allied website address is shown on the back of the ID card. You will receive your unique passwords that will allow you to access your personal eligibility/claims history and to view this document (and any amendments to it) 24 hours a day, 7 days a week through the use of this option. The site contains additional links and services you will find valuable in understanding and using your coverage effectively. Please take full advantage of this service.

GENETIC INFORMATION

The Plan may not adjust premium or contribution amounts for those covered under the Plan on the basis of genetic information. The Plan may also not request, require or purchase genetic information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts, and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his/her family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no genetic information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

PPO OPTION

The Plans contain a **PPO** (Preferred Provider Organization). The name of the organization is indicated on the front of your ID card, along with instructions regarding where to file medical claims. There are specific Hospitals and Physicians associated with the PPO, and benefits are generally paid at a higher level when using a PPO Hospital or Physician than when using non-network providers. Please refer to the following “Schedule of Covered Services” for benefits payable according to type of provider used. For assistance in locating a PPO provider near you, you may visit the PPO’s website listed on your ID card. However, because all providers have a free choice of whether or not to participate in a PPO network, there is always the possibility that information on the website may not be completely current. Therefore, as a final step in the process, call the “Provider Referral Number” listed on your ID card to verify that the provider is currently in the network. **It is your responsibility to be sure that you verify that a provider is in the PPO network you selected on the date that services are provided.**

If while being treated at a Network Hospital, services are performed by a Non-Network specialist (anesthesiologist, radiologist or pathologist) who is requested or required by that Network Hospital, the charges will be covered as if rendered by a Network Physician. **Covered services or items not available through the PPO Network** are covered at the level shown in the “Schedule of Covered Services”. Services available vary from network to network, and may change within a given network from time to time, so be sure to verify that a particular service is not offered by your PPO network before seeking service by an Out-of-Network provider.

A Covered Person has a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan. *If you need to be treated by a specific provider and that provider type is not available through the Network within 50 miles of your school’s Central office, the Plan will cover a non-network provider (under the 50 mile radius) as if the provider were In-Network. Reasonable and Customary will still apply.*

**MEDICAL CARE BENEFITS (INCLUDING MENTAL/NERVOUS
AND SUBSTANCE USE DISORDERS)**

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Calendar Year Deductible (taken before benefits are payable unless waived)	\$1,000/person \$2,000/family	\$2,000/person \$4,000/family						
	<i>Note that In-Network and Out-of-Network Deductibles are "separately tracked." That is, expenses applied to one do not apply to the other.</i>		\$2,750/person \$5,500/family		\$3,000/ person \$6,000/family		\$6,650/ person \$13,300/family	
Out-of-Pocket Maximum per Calendar Year <i>(Medical and Rx Co-Pays, co-insurance and deductibles count towards the Out-of-Pocket Maximum)</i> After amount is reached, 100% level of benefits applies for that Calendar Year. The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum:								
<ul style="list-style-type: none"> • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit 	\$4,500/person \$9,000/family		\$5,750/ person \$11,500/family	\$7,750/ person \$15,500/family	\$6,650/ person \$13,300/family	\$8,550/ person \$17,100/family	\$6,650/ person \$13,300/family	
			<i>In-Network and Out-of-Network Out of Pocket Maximums are "aggregated," such that Covered Services applied to one also apply to the other.</i>		<i>In-Network and Out-of-Network Out of Pocket Maximums are "aggregated," such that Covered Services applied to one also apply to the other.</i>			
							No Coverage non-emergency Out-of-Network services	
							No Coverage non-emergency Out-of-Network services	

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Benefits subject to penalties shown per occurrence (in addition to Deductible) for failure to follow the Pre-certification Requirements. Call Number on back of ID card and follow instructions (pgs 5-7) to avoid penalty.	<i>\$200 Non-Compliance Penalty for failure to follow requirements.</i>							
Calendar Year Benefit Maximum	Unlimited.							
Prescription Drug Card Program (up to 30-day supply through participating pharmacies) <i>Note - \$0 co-pay applies to smoking cessation medication</i>	100% after the following co-pays: \$15 for Generic, 30% of cost for Brand* (minimum of \$40, to a maximum of \$75 per prescription). *Note that - for brand drugs - a separate \$150 Deductible per person (\$300 per family) per Calendar Year must be met prior to the brand co-pay being applied. This is an embedded deductible, meaning each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.		Once the Calendar Year Deductible has been met, this Plan will pay covered prescription drugs at 90%.		Once the Calendar Year Deductible has been met, this Plan will pay covered prescription drugs at 80%.		Once the Calendar Year Deductible has been met, this Plan will pay covered prescription drugs at 100%.	
Mail Order Drug Benefit (up to 90-day supply per prescription through Mail Order Program) <i>For additional information on the Mail Order Drug Benefit see page 26 or call the toll free number listed on your ID card.</i>	100% after the following co-pays: \$30 for Generic, \$75 for Brand, <u>Deductible Waived</u>		Once the Calendar Year Deductible has been met, this Plan will pay covered prescription drugs at 90%.		Once the Calendar Year Deductible has been met, this Plan will pay covered prescription drugs at 80%.		Once the Calendar Year Deductible has been met, this Plan will pay covered prescription drugs at 100%.	

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Oral Specialty Drug Pharmacy Benefit <i>Please refer to Prescription Drug Benefit section for further details.</i>	50% of cost for Specialty (minimum of \$150, to a maximum of \$300 per prescription).		Please contact Express Scripts at 1-866-275-0044		Please contact Express Scripts at 1-866-275-0044		Please contact Express Scripts at 1-866-275-0044	
<p>Contraceptives Coverage - The School Employees' Benefit Trust (SEBT) Health Benefit Plan includes coverage for several types of contraceptives at no cost to you as the plan participant. Other contraceptives will remain covered for the standard co-pay. For additional information about your contraceptive benefits, including the applicable co-pay for a medication, please contact Express Scripts toll free at 1-866-275-0044 or online at www.express-scripts.com.</p>								
Primary Care/Urgent Care Physician Office Visit* <i>* Note that Primary Care Physicians are limited to: general practitioner, family practitioner, general internist, pediatrician, urgent care physician, and all covered mental health providers.</i>	\$30 co-pay per visit; then 100% <u>Deductible waived</u> , (for office visit charge and all other Medically Necessary services (including allergy injections) done that visit and billed by that provider). If no office visit charge is made (i.e., for only allergy injections), service is payable at 70%.	50% (all Medically Necessary services)	90%	70%	80%	60%	100%	No Coverage

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Specialist Physician Office Visit When SEBT is Primary Coverage under Coordination of Benefits rules <i>(includes all Medically Necessary services-including allergy injections-rendered during the office visit)</i>	\$60 co-pay per visit, then paid at 100% <u>Deductible waived.</u> If no office visit charge is made (i.e., for only allergy injections), service is payable at 70%.	50%	90%	70%	80%	60%	100%	No Coverage
Chiropractic Care <i>All services provided by a chiropractor are limited to a combined maximum of 26 visits per Covered Person per Calendar Year, regardless of the place of service or services provided. Does not include labs and x-rays; please see "Specialist Physician Services for Diagnostic Procedures not available in Primary Care Physician's office" on pg. 20.</i>	70%	50%	90%	70%	80%	60%	No Coverage	No Coverage
Hospital Emergency Room Care <i>(Co-Pay waived if admitted within 48 hours)</i>	\$200 co-pay per occurrence; then, 100% <u>Deductible waived</u>	\$200 co-pay per occurrence; then, 100% <u>Deductible waived</u>	90%	Paid Same as In-Network	80%	Paid Same as In-Network	100%	Paid Same as In-Network

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
<p>Preventive Care Services- <i>(must be billed with a routine diagnosis)</i></p> <p>This plan includes coverage for physical exams, immunizations, routine eye exams (from birth through age 5), tests, x-rays, pap smears and analysis, mammograms (age 35 and older, one per person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and sigmoidoscopies/colonoscopies (age 40 and older, every 5 Calendar Years, but not both). Note: for any of the services listed above, the first service done in any Calendar Year will be paid as routine, regardless of diagnosis. Also Note: If the Provider submits the claim with a diagnosis that is not “routine” (other than the first service), benefits will be subject to standard Plan provisions for Medically Necessary services.</p> <p>(This benefit specifically does not cover heart scans, full body scans, Executive Physicals, CAT scans, MRI’s, PET or other similar tests)</p>	100%	100%	100%	100%	100%	100%	100%	No Coverage
	<u>Deductible</u> <u>Waived</u>	<u>Deductible</u> <u>Waived</u>	<u>Deductible</u> <u>Waived</u>	<u>Deductible</u> <u>Waived</u>	<u>Deductible</u> <u>Waived</u>	<u>Deductible</u> <u>Waived</u>	<u>Deductible</u> <u>Waived</u>	<u>Deductible</u> <u>Waived</u>

This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) That Have Been Adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women’s Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
<p>Family History Coverage (includes administrative and medical procedures as recognized by the AMA for the purpose of determining the Covered Person's risk of developing breast cancer, ovarian cancer, myocardial infarction, colon cancer, inflammatory bowel disease, osteoporosis or diabetes, limited to those situations where an immediate family member (parent or sibling) was diagnosed with the disease.</p>								
<p>Family History Coverage continued:</p> <p><i>This benefit also allows for at least one (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age or is younger than fifty (50) years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society; as well as Colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic insured, in accordance with the current American Cancer Society guidelines for a covered individual who is fifty (50) years of age or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.</i></p> <p>Coverage is limited to a maximum of \$1,500 payment per all conditions per person per Calendar Year. After \$1,500 is paid, covered benefits will be subject to standard Plan provisions for Medically Necessary services.</p>	<p>If Primary Care Physician, \$30 office visit co-pay or consultation charge, then 100% <u>Deductible waived</u>. Other services payable at 70%</p> <p>\$60 specialist office visit co-pay per exam or consultation charge, then 100%. <u>Deductible waived</u>.</p> <p>Other services payable at 70%</p>	50%	100%. <u>Deductible waived</u> .	70%	100%. <u>Deductible waived</u> .	60%	100% <u>Deductible Waived</u>	No Coverage

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Breast Pumps and Supplies (Includes breast pumps and supplies purchased through a retail supplier). <i>Limited to a maximum payment of \$450 (includes pump and supplies) per person per pregnancy.</i>	100% <u>Deductible</u> <u>waived</u>	100% <u>Deductible</u> <u>waived</u>	100% <u>Deductible</u> <u>waived.</u>	100% <u>Deductible</u> <u>waived</u>	100% <u>Deductible</u> <u>waived.</u>	100% <u>Deductible</u> <u>waived</u>	N/A (see benefit below)	No Coverage
Breast Pumps and Supplies, breastfeeding support and counseling	N/A (see benefit above)		N/A (see benefit above)		N/A (see benefit above)		100% <u>Deductible</u> <u>waived</u>	No Coverage
Second Surgical Opinions <i>(third opinions also covered if first two disagree)</i>	70%	50%	90%	70%	80%	60%	100%	No Coverage
Specialist Physician Services for Surgery done outside of Physician's Office <i>(see also definition of "multiple Surgical Procedures" and note that Pre-Certification of Hospital Admissions may apply) including associated anesthesiology and pathology services.</i>	70%	50%	90%	70%	80%	60%	100%	No Coverage
Specialist Physician Services for Diagnostic Procedures not available in Primary Care Physician's office <i>(including administration of x-ray and laboratory tests and their interpretation through another provider)</i>	70%	50%	90%	70%	80%	60%	100%	No Coverage

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Other Specialist Physician Medical Care and Treatment including consultations, therapy and treatment	70%	50%	90%	70%	80%	60%	100%	No Coverage
Inpatient Hospital Services <ul style="list-style-type: none"> ▪ <i>Room and board not to exceed the semi-private room rate</i> ▪ <i>Necessary services and supplies including an intensive care unit and a cardiac care unit based on actual charges.</i> • <i>If admitted through the Hospital Emergency Room, this benefit will be covered at the In-Network level.</i> • <i>Must be Pre-certified.</i> 	70%	50%	90%	70%	80%	60%	100%	No Coverage
Outpatient Hospital Services <i>Certain Outpatient hospital services must be Pre-certified. See pages 5-7 for details.</i>	70%	50%	90%	70%	80%	60%	100%	No Coverage

SCHEDULE OF COVERED SERVICES

BENEFITS and PROVISIONS	Network Deductible Plan		CDHP Plan A		CDHP Plan B		CDHP Plan C	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Renal Dialysis (All dialysis providers are out-of-network. This Plan does not access or use the Aetna network for dialysis providers.) <i>Note: For charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses.</i>	70%	Paid Same as In-Network	90%	Paid Same as In-Network	80%	Paid Same as In-Network	100%	Paid Same as In-Network
Home Health Care (Requires Home Health Care Plan certified by Physician) Also requires Pre-certification.	70%	50%	90%	70%	80%	60%	100%	No Coverage
TMJ (Temporomandibular Joint Dysfunction) May require Pre-certification, see pages 5-7 for details.	70%	50%	90%	70%	80%	60%	No Coverage	No Coverage
Covered Services (Not Available In Network)	Not Applicable	70%	Not Applicable	100%	Not Applicable	80%	100%	No Coverage
Other Covered Services and Items (see pages 23-24)	70% Unless Covered Differently Under a Previous Category	50% Unless Covered Differently Under a Previous Category	90% Unless Covered Differently Under a Previous Category	70% Unless Covered Differently Under a Previous Category	80% Unless Covered Differently Under a Previous Category	60% Unless Covered Differently Under a Previous Category	100% Unless Covered Differently Under a Previous Category	No Coverage

OTHER COVERED SERVICES/ITEMS

Please read previous pages for detailed information regarding the coverage of services/items in and out of network under each of the Plans.

Pre-Admission Testing prior to an Inpatient Hospital admission or Outpatient surgery
Anesthesia and Its Administration <i>(Inpatient/Outpatient)</i>
Private Duty Nursing Services <i>of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.) other than one who ordinarily resides in your home, or who is a member of the immediate family, when Medically Necessary</i>
Diagnostic Services , <i>including radiology, ultrasound and nuclear medicine, pathology services, CAT scans and MRI, EKG, EEG and other electronic diagnostic medical procedures, and diagnostic laboratory procedures</i>
Radiation Therapy, Chemotherapy and Inhalation Therapy
Physical and Occupational Therapy <i>All services rendered by physical therapists/occupational therapists are limited to a combined maximum of 26 visits for office and Outpatient facility services, per Covered Person per Calendar Year.</i>
Speech Therapy <i>is limited to a maximum of 26 visits for office and Outpatient facility services, per Covered Person per Calendar Year.</i>
The medically necessary treatment for diabetes , including medically necessary supplies and equipment as ordered in writing by a physician or a podiatrist subject to general provisions of the health benefit plan
Medical Supplies <i>such as syringes, needles, oxygen and colostomy bags, but not items usually stocked in the home such as bandages and petroleum jelly.</i>
Covered Medically Necessary Prescription Drugs <i>if not available through the Prescription Drug Card or Mail Order Programs</i>
<i>Processing and administration of Unreplaced Blood and its components</i>
Professional Ambulance Service , <i>from the city or town in which the Employee or covered Dependent becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease. <u>Note:</u> Ambulance Charges: For ambulance (ground and air) charges exceeding \$5,000, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. Charges include those which relate to 1) transportation and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies.</i>
<i>Purchase of Prosthetic Appliances used to aid in the function of or to replace a limb or organ if the appliance is the original appliance or a replacement is required by pathological change or normal growth</i>
Mastectomy Brassieres
Dressings, Casts, Splints, Trusses, Crutches and Braces
Syringes/needles, pumps and/or disposable testing supplies for insulin.
Oxygen <i>and rental of equipment for administration of oxygen; purchase and/or rental of Durable Medical Equipment (up to purchase price). Note: DME Equipment and associated supplies through Direct Healthcare Supply is paid at the PPO level with fee schedule.</i>
Allergy Shots <i>(injections)</i>

OTHER COVERED SERVICES/ITEMS

First Pair Of Glasses or Contact Lenses, but not both, needed after cataract surgery *

Dental Treatment when rendered by a Physician, Dentist or oral surgeon for **a fractured jaw** or of **accidental** (non chewing) **Injuries to natural teeth** (replacement or repair of a denture not covered); treatment or removal of a **tumor**; removal of **impacted teeth**; **medical care, services and supplies** furnished by a Hospital during Medically Necessary confinement in connection with dental treatment.*

* Note that dental or vision practitioners are allowed to refer to medical Specialist Physicians when possible medical issues are discovered during dental or vision services.

Routine Newborn Nursery Care (including circumcision)

Consultation services (requested by attending Physician when patient is Hospital confined; limit of one consultation per confinement)

Maternity Services for obstetrical deliveries and related anesthesia, prenatal and postnatal care that is received by a covered Employee, spouse, or Dependent daughter.

Voluntary Sterilization and Voluntary Abortion

Hemodialysis treatment

Assistant Surgeon services (as Medically Necessary due to complexity of surgery)

Extended Care Facility (also known as Skilled Nursing Facility). Admission must be within 3 days of a prior Inpatient Hospital stay, be ordered by your Physician, be for care and treatment of the same Illness or Injury for which you were hospitalized, or otherwise be in lieu of Inpatient hospitalization. Covered Charges include:

- room, board and floor nursing care (limited to a maximum of 90 days per Calendar Year)
- physical therapy, occupational or speech/hearing therapy
- drugs, biologicals, supplies, appliances and equipment for use in the facility ordinarily furnished by the facility for the care and treatment of inpatients

Pre-certification is required.

Hospice Care (for Covered Persons certified by their doctor as terminally ill – i.e., with a life expectancy of less than 6 months; Covered Charges include all medical and psychological services normally provided to the Covered Person on an Inpatient or Outpatient basis, as well as pastoral services and family counseling provided to immediate family by a licensed or certified psychologist/counselor prior to patient’s death, and bereavement services within 6 months following the patient’s death). Inpatient Hospice requires Pre-certification (except Medicare).

Home and Inpatient Visits by a Physician as Medically Necessary

Mental, Nervous and Substance Use Disorders Treatment Eligible expenses payable same as any other eligible medical expense. See General Limitation #21 and definition of “Mental/Nervous and Substance Use Disorder” on page 43.

Organ or Tissue Transplants for cornea, kidney or skin transplants; also for the following human-to-human organ or tissue transplants: bone marrow, heart, heart/lung, liver, lung and pancreas, if the following conditions are met: the Covered Person, who is the transplant recipient, must receive two opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.

In no event will benefits be paid for experimental or investigational services; or, for treatment not deemed clinically acceptable by (a) the National Institute of Health; or (b) the FDA; or (c) a similar national medical organization of the United States

**See “General Limitations” & “General Provisions”
For Additional Coverage Details, Exclusions and Limitations**

PRE-DETERMINATION OF BENEFITS

This is a system designed to assist you and your Physician in understanding your medical coverage before the services are provided. If you would like to know how specific services will be paid prior to the treatment being done, your Physician may submit a predetermination form showing the diagnosis, proposed service and associated fees to the Plan Supervisor (Allied Benefit Systems, Inc.). A determination will be made as to the benefits payable according to the terms of this Plan, and a response will be sent to the Physician. You and your Physician can then discuss the proposed procedures and benefits. **Note: this procedure does not guarantee payment.** The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are actually rendered.

PRESCRIPTION COVERAGE

Prescription drug coverage is provided through a separate company referred to as a P.B.M. (Prescription Benefit Manager). Refer to your ID card for contact information.

Prescriptions may be acquired through local or national participating retail pharmacies, or through the P.B.M.'s sponsored Mail Order program.

Retail Drug Card Benefit: *(applicable to the Network Deductible Plan, and those members in the CDHP Plans that have met the Calendar Year Deductible)*

The Drug Card Benefit permits up to a 30-day supply of medication and up to one year of refills upon authorization. Benefits will be paid after the Deductible and/or Co-Pay amounts shown in the "Schedule of Covered Services" for charges made by a participating pharmacy for treatment of a Covered Person's Illness or Injury. A covered charge is considered made on the date the prescription is dispensed by the pharmacist. Please refer to Prescription Management Program; Prescription Exclusions and Limitations.

Discount Drug Card Benefit: *(applicable to members in the CDHP Plans that have not met the Calendar Year Deductible.)*

Note that your Plan has provided you with a discount drug card which should be presented to participating pharmacies. You must pay the full price for covered retail drugs at the time of purchase. However, with the card, you are guaranteed the best price possible, in that store, on that day, for medications purchased.

Mail Order Drug Benefit:

This benefit offers a mail order service which delivers required prescription drugs directly to your home. See “Schedule of Covered Services” for coverage details under the Network Deductible Plan vs. the CDHP Plans. The Mail Order Drug Benefit permits up to a 90-day supply of medication and up to one year of refills upon authorization.

The Mail Order Drug Benefit has the same coverage and exclusions as your Prescription Drug Card. However, it is expected that certain types of prescriptions needed immediately for acute needs would normally be provided under the Prescription Drug Card. **Note:** Your Mail Order Drug Plan offers discounts on non-covered prescription drugs. Whether or not a particular drug is covered under Plan provisions, you will receive the benefit of paying the discounted price for that drug if you order it through the Mail Order Drug Program.

Prescription Coverage, Exclusions and Limitations

See details on the following pages. Also, review the “Prescription Coverage Management Program” following that section for details on how the P.B.M. monitors drug utilization to avoid possible drug conflicts and to assure that the highest quality drug choices are offered to your Physician on the most cost effective basis for you.

PRESCRIPTION DRUG COVERAGE, EXCLUSIONS AND LIMITATIONS:

COVERED DRUGS:

The following are considered covered benefits unless noted on the following pages as an exclusion or limited benefit:

- Federal (United States) Legend Drugs (including oral and injectable contraceptives, and contraceptive devices);
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- OTC Diabetic Supplies
- AIDS Medications
- Chemotherapy Medications
- Your pharmacy vendor’s Self Injectable List
- Insulin Pumps and associated supplies

- Smoking Cessation medications (\$0 co-pay applies)
- Weight Loss medications \$500 calendar year limit, \$1000 lifetime.

QUANTITY LEVEL LIMITS:

- Note that certain medications may have specific quantity limitations that are not the standard supply limit. You will be notified if this is the case either by the pharmacist or through the mail order process.

PRIOR AUTHORIZATION REQUIREMENTS:

- Certain medications may need to have additional clarifications or authorizations made prior to their being dispensed. You will be provided with details through the mail order process if this situation should occur when using that program. If this should occur during your purchase of a retail drug, the pharmacist will provide you with a toll free number for you to contact the pharmacy vendor and initiate this process. In rare cases (primarily involving growth hormones) you may need to contact the P.B.M. in order to determine whether a specific medication or quantity of medications would be covered.

EXCLUSIONS:

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- Non-Federal Legend Drugs
- Injectable Medications (except for those listed above)
- Fertility Medications
- Allergy Serum
- Topical Fluoride Products
- Ostomy Supplies
- Therapeutic devices or appliances
- Mifeprex
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Immunization agents and Vaccines
- Biologicals, Blood or Blood Plasma Products
- Non-Sedating Antihistamines (NSA), however the Plan may allow for an NSA Medication and/or NSA Decongestant combination with Prior Authorization. This exemption may be allowed after the member has tried an OTC alternative with unsuccessful results and has secured a prescription for an NSA meeting medical necessity criteria.

- Prescription and/or over the counter vitamins, other than prenatal vitamins
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

Note the following Prescription Drug Exclusions apply to CDHP-C only:

- Proton pump inhibitors (PPI's)
- Lifestyle medications

SPECIALTY DRUG PHARMACY BENEFIT

Certain specialty medications may be required to be purchased through Your pharmacy vendor's or Allied's specialty pharmacy program. Typically, these medications are very costly, require special storage or handling, are for long term use, or require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in this specialty pharmacy program, or You may call the pharmacy vendor (see Your member ID card) as soon as a drug has been prescribed to determine how it must be dispensed. The specialty pharmacy unit will coordinate fast shipment to the location a member chooses, such as Your home or Your Physician's office. Alternatively, if Your pharmacy vendor indicates that they cannot dispense the drug, please contact Allied's customer service team (see Your member ID card) to determine how the specialty drug that has been prescribed must be dispensed. Please refer to previous pages for coverage provisions.

Prescription Coverage Management Program

- Your P.B.M. will identify quality and cost opportunities based on medical criteria recognized by the medical and pharmacy communities at the point a prescription is placed to be filled.

- They look for possible conflicts with the diagnosis and standard drug use; possible multi-drug interactions; untried first or second line medication options, etc.
- The P.B.M. will contact your Physician on your behalf to discuss the opportunity. The Physician has the final determination for prescription use, NOT the P.B.M.
- The determination (whether the Physician re-issues the prescription or supports the first order) is maintained in the P.B.M. database for one year. Prior to the year expiration, a letter will be mailed to the member indicating the review process needs to be updated if continued use of the medication is needed.
- This Plan does not cover any secondary claims on prescription drugs. Prescription drugs will only be paid on claims incurred by members with primary prescription drug coverage through SEBT.

What you need to expect:

- If your prescription drug use qualifies for coverage management, you will receive information in your mail from the P.B.M. for further information.
- Upon refill or issuance of a new, qualifying medication, the P.B.M. pharmacist will contact your physician as mentioned above.
- If it is Mail Order (which most should be), it will add a day or so to the turnaround time. If your doctor re-writes your prescription, you will be notified.
- If it is Retail, you may need to wait or re-visit the pharmacy upon determination.

GENERAL LIMITATIONS

No payment will be made under this Plan for expenses incurred by a Covered Person:

- 1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation or similar law (however, this limitation will not apply to the Employee if the respective Workers' Compensation Regulations do not require coverage of the Employee and the Employee has not obtained such coverage.);*
- 2. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;*
- 3. for charges which the Covered Person is not legally required to pay or for charges which would not have been made if no coverage had existed;*
- 4. which are in excess of Reasonable and Customary Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers);*
- 5. which are for care or treatment which is not Medically Necessary;*
- 6. which are for services provided or expenses incurred prior to your effective date; for services for an Inpatient Hospital admission which began prior to your effective date; for services provided after your termination date;*
- 7. for routine eye examinations; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses (except as provided under the "Schedule of Covered Services"); for eye surgery such as radial keratotomy; for routine hearing examinations, hearing aids, or the fitting thereof;*
- 8. for routine foot care such as removal of corns and calluses; for trimming of toenails; for treatment of weak feet, fallen arches or chronic foot strain;*
- 9. for custodial care. (Expenses incurred to assist a person in Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected daily living activities are considered costs for custodial care. to improve a medical condition.);*
- 10. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities*

- resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services referenced under the definition of “Reconstructive Breast Surgery Coverage”); or to correct a functional disorder (functional disorders do not include mental or emotional distress related to a physical condition); or unless treatment is for correction of an abnormal congenital condition;*
- 11. due to Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault or felony; or which is caused by war, declared or undeclared, or any act of war; or for services payable under government programs or private medical research programs;*
 - 12. for treatment of or to the teeth, the nerves or roots of the teeth (except as stated under the “Schedule of Covered Services”); for the repair or replacement of a denture;*
 - 13. for check ups and immunizations, including screening, routine physical examinations and research studies not reasonably necessary to the treatment of an Illness or Injury (except as stated under the “Schedule of Covered Services”);*
 - 14. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;*
 - 15. for occupational therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function;*
 - 16. for speech therapy when it is rendered for other than the correction of a physical impairment caused by Illness, Injury or congenital deformity;*
 - 17. for purchase or rental of personal comfort items or supplies of common use; for purchase or rental of blood pressure kits; exercise cycles; air purifiers; air conditioners; water purifiers; hypo-allergenic pillows; mattresses or waterbeds; escalators; elevators; saunas; steamrooms and swimming pools;*
 - 18. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician (except as stated in the Schedule of Covered Services); for surgery or treatment for obesity except in cases of Morbid Obesity when the Covered Person is twice his/her ideal weight or greater than 100 lbs. overweight and suffers from documented separate conditions which are aggravated by the morbid obesity);*

19. *for special education, counseling, or other services for diagnoses pertaining to developmental delay, learning deficiencies or behavioral problems, unless:*
 - *the diagnosis is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered, and*
 - *the treatment provided and the provider of such treatment is not excluded under any other provision of the Plan;*
20. *for non-medical expenses such as preparing medical reports, itemized bills or charges for mailing; for training, educational instructions or materials, even if they are performed or prescribed by a Physician; for legal fees and expenses incurred in obtaining medical treatment;*
21. *for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24 hour period immediately following admission;*
22. *for expenses in connection with in-vitro fertilization, artificial insemination or fertility drugs (except as stated); for reversal of voluntary sterilization; for contraceptive medications (except as stated) and devices; for treatment for sexual dysfunction or inadequacy (except as stated), including implants and related hormone treatment;*
23. *for treatment by a Physician, R.N., L.P.N. if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Covered Person or a spouse; for treatment provided by any person who ordinarily resides with the Covered Person;*
24. *for experimental or investigational services as defined in the Aetna Clinical Bulletins, or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States; notwithstanding the foregoing, the Plan may provide coverage for claims incurred through Sutter Health and its affiliates. (“Sutter”) may require payment of certain claims that would otherwise be denied, such as those not medically necessary, or experimental or investigational (but does not require payment for services that the Plan expressly excludes from coverage, such as for cosmetic surgery). Both the Retiree, and/or Dependent of the Retiree, and the Plan will be charged for these claims in order to be able to continue providing Retiree, and/or Dependent of the Retiree, with access to Sutter’s services on an in-network basis. The Plan will also provide coverage for off-label use of*

any medical device, drug or biological product that:

- (a) has received FDA approval for one or more specific diagnoses; and*
- (b) is prescribed for another condition or diagnosis; and either (c) or (d):*
- (c) such use for another condition or diagnosis is recognized by at least one of the following:*

*The American Medical Association Drug Evaluations,
The American Hospital Formulary Service Drug
Information, or
The United States Pharmacopoeia Drug Information;
or*

- (d) such use for another condition or diagnosis is recognized as appropriate by at least one of the following:*

*Peer-reviewed scientific studies accepted for publication by a medical journal meeting nationally-recognized requirements for scientific manuscripts and written by experts not part of such journal's editorial staff; or
Peer-reviewed literature, biomedical compendia and other medical literature that meet the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus or similar index; or Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act; and has not been found by the FDA to be contraindicated for the specific treatment for which it is being prescribed.*

- 25. for any secondary claims on prescription drugs. Prescription drugs will only be paid on claims incurred by members with primary prescription drug coverage through SEBT.*
- 26. for vitamins (except prescription pre-natal vitamins); for over-the-counter drugs regardless of being prescribed by a Physician;*
- 27. for "nicotine patches" or other forms of anti-smoking medication (except as stated under the Prescription Drug Card provision); for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless specifically provided;*
- 28. for any expense in excess of any maximum or limit as stated elsewhere in this document;*

29. *for services related to any Illness or Injury which is caused by atomic explosion or other release of nuclear energy, whether or not the result of war; for expenses incurred as a result of radioactive contamination or the hazardous properties of nuclear material;*
30. *when medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles; this Plan shall always be considered the secondary carrier regardless of the individual's election under "PIP" (Personal Injury Protection) coverage with the auto carrier;*
31. *for provider charges claimed as a result of purported lost discounts.*
32. *for charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. (All dialysis providers are out-of-network. This Plan does not access or use the Aetna network for dialysis providers.);*
33. *for ambulance (ground and air) charges exceeding \$5,000, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. Charges include those which relate to 1) transportation and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies;*
34. *CDHP Plan C only: for chiropractic care;*
35. *CDHP Plan C only: for Temporomandibular Joint Dysfunction;*
36. *CDHP Plan C only: for all Out-of-Network non-emergency services.*

See also "General Provisions"

MEDICARE BENEFITS

Under federal law, Employees in active service aged 65 and over and Dependent spouses aged 65 and over of Employees in active service may make an election regarding the program of health benefits under which they desire to be covered. Medical benefits payable under the Plan for such persons shall be the same as the benefits for Covered Persons who are under the age of 65.

If an Employee is actively working for the Employer when he attains age 65, such Employee may choose either the Plan or Medicare for health benefits coverage until such time as that Employee is no longer actively working for the Employer.

If the Dependent spouse of an Employee attains age 65 while such Employee is actively working for the Employer, such Dependent spouse may choose either the Plan or Medicare for health benefits coverage until such time as the Employee is no longer actively working for the Employer.

If Medicare benefits are paid for expenses not covered under this Plan, they will not be used to reduce benefits under this Plan. In the case of services and supplies for which Medicare makes direct reimbursement to the provider, the amount of expenses and Medicare benefits will be determined on the basis of the Reasonable and Customary charges for the services and supplies.

Contact your local Social Security office to fully understand your Medicare enrollment options, the impact of your enrollment elections, and the available timelines for coverage options.

DEDUCTIBLE/CO-INSURANCE

Upon receipt of satisfactory proof that a Covered Person has incurred Covered Services as a result of an Injury or Illness, the Plan, after deducting the Deductible Amount shown in the “Schedule of Covered Services” from the Covered Services first incurred during that Calendar Year, will pay benefits at the appropriate Co-Insurance level as shown in the “Schedule of Covered Services”. Note that In-Network and Out-of-Network Deductibles are “separately tracked.” That is, expenses applied to one do not apply to the other.

COMMON ACCIDENT PROVISION

If two or more covered family members are injured in the same accident and incur Covered Services for the Injuries, only one Deductible (the largest) need be satisfied for all.

FAMILY DEDUCTIBLE

Each covered individual is required to meet the individual deductible amount shown unless the family deductible is met (which can be accomplished by any combination of family members contributing any deductible amounts toward the overall family deductible).

OUT-OF-POCKET MAXIMUM

The “Out-of-Pocket Maximum” is the total amount of Co-Insurance (includes the Deductible, Rx co-pays and Medical co-pays) for which the Covered Person or Covered Family is responsible during the course of a Calendar Year. These amounts are shown in the “Schedule of Covered Services”. However, the following items do not apply to, and are not affected by, the Out-of-Pocket Maximum:

- “Non-compliance penalty” (for failure to abide by pre-certification requirements)
- Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit.

DEFINITIONS

Certain words and terms used herein shall be defined as follows:

ADMINISTRATOR

The person or entity responsible for the day-to-day functions and management of the Plan. The Administrator may employ persons or firms to process claims and perform other Plan connected services. The Administrator is the Company.

ALLOWABLE AMOUNT

As you review the Schedule of Covered Services, it is important that you keep in mind that all Out of Network Providers for your Plan, are subject to Reasonable and Customary Charge limitations. This means that the maximum allowable amount for all Out of Network services is based on the definition of “Reasonable and Customary” (see page 45). Normally, the Plan’s payment will be a percentage of that amount (see “Schedule of Covered Services”). However, in any case where the provider’s total charge exceeds the Reasonable and Customary charge, the excess amount is not eligible under the Plan, although the provider is free to balance bill the patient since no contract provisions prevent this course of action.

On the other hand, if the Covered Person utilizes an In-Network provider, the maximum allowable amount is based on a contracted fee schedule. Therefore, any amount of the provider’s bill over the maximum amount allowed by the Plan is not subject to balance billing by the provider in these cases.

AMBULATORY SURGICAL CENTER

Any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient surgical procedures; c) continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

ASSISTANT SURGEON

The Plan will cover charges for an assistant to help your surgeon if one is Medically Necessary because of the complexity of the surgery or the nature of your condition. Plan payments for an Assistant Surgeon will be limited to a 20% of the primary Physician’s payment.

CALENDAR YEAR

That period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

CASE MANAGEMENT PROGRAM

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

Note: The term Case Management shall also apply to those situations where the Plan approves an alternate level of benefits for Outpatient visits in lieu of Inpatient hospitalization at the request of the patient's Physician.

CLAIMS PROCESSOR

The entity providing consulting services to the Company in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, Inc., P. O. Box 909786-60690, Chicago, IL 60690.

COMPANY

The Company shall mean School Employees' Benefit Trust (SEBT).

COSMETIC SURGERY/TREATMENT

Surgery or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or trauma, or a disfiguring disease).

COVERED PERSON

A Covered Person is an Employee, Dependent Spouse, or Dependent Child that satisfies the Eligibility* and premium contribution requirements of the Plan. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse. *Please reference the Eligibility For Coverage section to review the Eligibility requirements for each Covered Person.

DEDUCTIBLE

The amount of eligible expense incurred in any Calendar Year, which must be satisfied by the Covered Person before benefits are paid.

DEPENDENT CHILD

Married or unmarried children from birth to the last day of the month they attain age 26. The term “*child*” or “*children*” means children placed for adoption, adopted children, stepchildren, children for whom you or your spouse are legal guardians, or children that the Employee is obligated by judgment or court decree to pay such child’s medical expenses or to provide medical insurance on behalf of the child.

A child who is physically or mentally incapable of self-support upon reaching the last day of the month they attain age 26, may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee’s own coverage continuing in effect. To continue a child under this provision, the Company must receive proof of incapacity within 120 days after the end of the Calendar Year in which the limiting age is reached. Additional proof will be required from time to time.

Please reference the Eligibility For Coverage section to review the Eligibility requirements for each Dependent Child.

DEPENDENT SPOUSE

A Dependent Spouse who is married to or survives an Active Employee. This Plan defines “marriage” as both 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage, and 2) a legal union between two persons of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement, nor does it include a legally separated spouse.

Note: Surviving Spouses’ are those who were on the Plan as a Covered Dependent Spouse of an Employee, and remain covered as a Spouse of an Employee following the death of the Employee.

Please reference the Eligibility For Coverage section to review the Eligibility requirements for each Dependent Spouse.

ELECTIVE SURGICAL PROCEDURE

Any non-emergency surgical procedure which may be scheduled at a patient’s convenience without jeopardizing the patient’s life or causing serious impairment to the patient’s bodily functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

EMERGENCY ROOM SERVICES

“Emergency Room Services” is defined as, with respect to a Medical Emergency, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the patient.

EMPLOYEE (ACTIVE)

All certified employees working under a contract, all other regular paid employees working at least 15 hours per week, bus drivers, employees contracted by the Trust to provide chief administrator support, and Members of the School Board of Trustees.

Please reference the Eligibility For Coverage section to review the Eligibility requirements for an Employee.

EMPLOYER

The Employer shall mean participating employers of the School Employees’ Benefit Trust (SEBT). Under no circumstances shall SEBT be considered an Employer.

ESSENTIAL HEALTH BENEFITS

“Essential Health Benefits” include the following general categories and the items and services covered within the 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 services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXTENDED CARE FACILITY

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical

necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the aged, drug addicts, alcoholics, mentally retarded persons, or a place for rest, custodial or educational care or for the care of mental disorders.

GENDER NEUTRAL WORDING

A masculine pronoun in this document shall at all times be considered synonymous with a feminine pronoun unless the context indicates otherwise.

GENETIC INFORMATION

The term "genetic information" is defined as 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a disease or disorder in family members of such individual. The term "genetic information" also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term "genetic information" further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

HOME HEALTH CARE AGENCY

A public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services and is either (1) licensed or certified as a home health agency by the governing jurisdiction; or (2) certified as a home health agency by Medicare.

HOSPICE

A facility established to furnish terminally ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A hospice must be approved as meeting established standards, including any legal licensing requirements.

HOSPITAL

An institution which meets all of the following requirements; (a) maintains permanent and full-time facilities for bed care of resident patients; (b) has a doctor in regular attendance; (c) continuously provides 24 hour a day nursing services by Registered Nurses (R.N.); (d) is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Injuries or Illnesses on a basis other than a rest home, nursing home, convalescent home, or a home for the aged;

(e) maintains facilities on the premises for surgery; (f) is operating lawfully as a Hospital in the jurisdiction where it is located; (g) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations or is Medicare approved.

In addition, the term “*Hospital*” shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

HOSPITAL SEMI-PRIVATE

The charge by the Hospital for semi-private room and board accommodations or the average semi-private room rate of other Hospitals in the same geographical area if the Hospital does not provide semi-private accommodations.

ILLNESS

Only non-occupational sickness, disease, mental infirmity or pregnancy, all of which require treatment by a Physician.

INJURY

Only non-occupational bodily Injury which requires treatment by a Physician.

INPATIENT

A Covered Person shall be considered to be an “*Inpatient*” if he is a registered bed patient in a health care facility for whom a room and board charge is made.

LATE ENROLLMENT

An enrollment which takes place after the 60 day period following the individual’s initial eligibility for coverage (other than during Special Enrollment or the annual Open Enrollment period of each year). *Late enrollments are not allowed under the Plan unless there is a Special Enrollment Event or the enrollment occurs during the normal Open Enrollment period (see page 52).*

LIFETIME

Shall mean, “*while covered under the Plan*”. Under no circumstances will the word “*Lifetime*” mean “*during the lifetime of the Covered Person.*”

MEDICAL EMERGENCY

A “**Medical Emergency**” is defined as 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) a condition 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.

MEDICALLY NECESSARY

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient’s condition or the quality of medical care rendered.

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES

Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered, and for which a Covered Person is eligible to receive benefits under the terms of this Plan.

MULTIPLE SURGICAL PROCEDURES

If more than one surgical procedure is performed during an operative session, the primary procedure will be considered at 100% of the allowable charge, and additional procedures will be considered at a lesser percentage, which is usually 50% of the normally allowable charge. Incidental procedures are not covered.

NAMED FIDUCIARY

The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Employer, who is the sponsor of this Plan. In exercising its fiduciary responsibilities, the Employer shall have the discretionary authority to determine eligibility for benefits, review denied claims for benefits, interpret Plan provisions, construe disputed Plan terms and select managed care options. The Employer shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

OUTPATIENT

A Covered Person shall be considered to be an “*Outpatient*” if he is treated at a Hospital and is confined less than 18 consecutive hours.

PHYSICIAN

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D), Speech Language Pathologist, Acupuncturist, and any other practitioner of the healing arts who is licensed and/or certified, and regulated by a state or federal agency and is acting within the scope of his or her license and/or certification.

For the treatment of mental illness, nervous disorders, alcoholism and drug abuse, the term “Physician” will also include Social Workers. The Social Worker must be a licensed or certified psychologist, counselor, or therapist and must work under the direct supervision of an M.D. with a psychiatry specialty.

PLACEMENT FOR ADOPTION

The assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

PLAN

The benefits and provisions for payment of same as described herein are called the School Employees’ Benefit Trust (SEBT) Employee Benefits Plan.

PLAN ADMINISTRATOR / PLAN SPONSOR

The entity responsible for the overall management of the Plan. The Plan Administrator / Plan Sponsor is the Board of Trustees of the School Employees’ Benefit Trust (SEBT).

PLAN SUPERVISOR

The entity providing consulting services to the Company in connection with the operation of the Plan and performing other functions, including processing of claims. The Plan Supervisor is Allied Benefit Systems, Inc., P. O. Box 909786-60690, Chicago, IL 60690.

PLAN YEAR

The 12-month period defined under the section “General Provisions”, sub-section “Administration of the Plan” in this document.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and your current plan offers dependent coverage, you will be required to provide coverage for any child(ren) named in the QMCSO.

If you do not enroll the child(ren), your employer must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to your employer that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

REASONABLE AND CUSTOMARY

The usual charge made by a Physician or supplier of services or supplies which shall not exceed the general level of charges made by others rendering or furnishing such services or supplies within the area in which the charge is incurred for Illnesses or Injuries comparable in severity and nature to the Illness or Injury being treated. The term "*area*" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of level of charges. This provision applies to Out-of-Network providers only.

RECONSTRUCTIVE BREAST SURGERY COVERAGE

The Plan will provide the following additional benefits to Covered Persons who are receiving Plan benefits in connection with mastectomy coverage: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions.

RETIREE COVERAGE Please reference the Medical and Prescription Benefits Booklet for Retirees and their Dependents.

SECOND SURGICAL OPINION

Shall mean a written statement on the necessity for the performance of a covered surgical procedure. This Second Surgical Opinion must be given by a board-certified specialist who, by the nature of the Physician's specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.

SPECIAL ENROLLMENT

An enrollment which takes place during the 60-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility For Coverage" section for details.

ELIGIBILITY FOR COVERAGE

Non-Discrimination

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

ACTIVE EMPLOYEE AND DEPENDENT COVERAGE

Employee Coverage

An Employee is required to meet the eligibility criteria outlined by this Plan and the criteria established at the Employee's School Corporation through which they are employed.

All Employees shall be eligible as of the date they enter an eligible class of Employees.

* Please reference definition of "Employee" on page 42.

Note: School Board Members and their Covered Dependents who wish to continue coverage beyond the Board Member's term of elected office may exercise COBRA privileges. They shall not be entitled to continued coverage as a Retiree or Dependent of a Retiree.

Spouse Coverage

Spouses shall be covered simultaneously with Employees covering them as Dependents.

In order to be eligible for Standard Dependent Coverage, the spouse may be required to supply on an annual basis sufficient documentation of the conditions that may allow coverage under this Plan. Such information may include, but is not limited to, employment verification, employer health plan offerings and documentation, retirement status and related materials.

The Employee or their spouse will need to provide all information required to administer this provision through the initial enrollment form or through the COB Questionnaire form until the Claim Administrator has received all required documentation, any claims for the Spouse will be denied, or returned to sender. Such documentation may also be required periodically to verify continued eligibility under the Plan in the future.

Spouse Eligible for Other Coverage

Your SPOUSE may not be eligible to participate in the School Employees' Benefit Trust plans, according to IRS rules, if he/she is an owner of a Health Savings Account (H.S.A.) receiving current contributions from the spouse or their employer. They cannot be "double covered" according to the IRS rules.

Spouses of an Employee that are eligible/entitled to other coverage through another employer-sponsored medical plan, retiree plan, Medicare, or TriCare, must take that coverage on an individual basis as "primary" insurance in order to be covered with the SEBT Plan for "secondary" insurance coverage only.

Spouses of an Employee may still join the plan as "primary" (and qualify for a waiver exemption) if they meet one of the criteria below:

- They are unemployed or self-employed or work for another School Employees' Benefit Trust participating group.
- The spouse is employed by an employer that does not offer or provide a group health plan to their employees.
- They are retired and only eligible for Medicare or TriCare.
- The spouse is eligible for the SEBT Plan through his/her participating school employer.
- They are actively employed and eligible for employer coverage but pay more than 60% of the single premium rate.
- They are retired and eligible for group sponsored retiree coverage but pay more than 60% of the single premium rate.

Reference the Coordination of Benefits section to review the Coordination of Benefit provisions for Employed Spouses.

Dependent Coverage (of Employee)

Each Dependent of the eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

1. The date the Employee is eligible; or
2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

Family Coverage:

If You have family coverage, Your newly-eligible Dependent child becomes eligible for coverage from the moment the child qualifies, provided You actually enroll the newly-eligible dependent child in Your coverage within 60 days of the qualifying event.

A newly-eligible dependent child is permitted to obtain coverage retroactively from the moment of birth, adoption, or for whom You assume legal responsibility, even if after the 60-day enrollment period. However, no claims will be processed for the newly-eligible dependent child until the individual's enrollment record is received and all verification documents are provided and approved.

Note: For so long as the IRS regulations require: If the spouse or dependent child of an eligible Employee is also covered under a high deductible health plan (HDHP) and contributing to a health savings account (HSA), then he or she is not eligible to participate in this Plan.

Standard Individual Effective Date

All persons become covered, as they become eligible subject to the following:

1. All Employees, who are eligible Employees, shall be covered on the day they enter an eligible class of Employees, providing enrollment is done within the 60-day period following initial eligibility.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within sixty (60) days from date of marriage.
4. Coverage for a newborn birth child will begin from the date of birth. Coverage for an adopted child or a child placed for

adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or a child in a legal guardianship status will begin from the date the child meets the definition of “Dependent.” With respect to a newborn birth child, coverage will begin upon birth for a period of sixty (60) days and will continue provided the child is formally enrolled in the plan within sixty (60) days from birth. With respect to an adopted child or child placed for adoption, if Dependent Coverage does not already exist, the child must be formally enrolled and appropriate coverage arranged within sixty (60) days from the date of Placement For Adoption. With respect to a stepchild or a child in a legal guardianship status, if Dependent Coverage does not already exist, the child must be formally enrolled and appropriate coverage arranged within sixty (60) days from the date that the child meets the definition of “Dependent.”

Special Enrollment

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and loses that coverage whether voluntarily or involuntarily. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children’s Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended.

Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;
- death;
- termination of employment, or reduction in hours of employment;
- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- reaching the Lifetime limit for all benefits under other coverage. The Special Enrollment period in this instance would be 30 days after the earliest date that a claim is denied due to reaching the lifetime limit.
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals.
- The Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 31 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

Late Enrollments

Except under Special Enrollment or during the period designated as Open Enrollment (see below), any Employee or Dependent electing to enroll later than 60 days after their respective eligibility date shall not be allowed to enter the Plan.

Open/Switch Enrollment

Each year an annual period, specified by the Plan Administrator, is designated an "Open/Switch Enrollment" period. During this time, an Employee or Dependent who did not enroll at initial eligibility may enroll and coverage will begin on the first day of the following year. Also, an Employee who wishes to change coverage from one plan to the other may do so at this time and any limitations that would apply under the old plan will continue to apply under the new plan. It is only during this period that you can make a change without a qualifying event.

INDIVIDUAL TERMINATION OF COVERAGE

The coverage of any Employee covered under this Plan shall terminate on the earliest of the following:

1. The date of termination of the Plan; or
2. The date the Employee ceases to be eligible for coverage under the Plan; or
3. The later of the date on which employment terminates or the last date for which you have paid the required contribution.

The Dependent's Coverage with respect to each Dependent shall cease on the date such individual ceases to be a Dependent as defined in this Plan. The Dependent's coverage with respect to all Dependents of an Employee shall cease on the date the Employee's coverage terminates.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than 1 coverage exists, 1 plan normally pays its benefits in full and the other plans pay a reduced benefit. 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. Only the amount paid by the Plan will be charged against the Plan maximums.

When the Spouse is enrolled in or entitled to a plan maintained by his/her Employer, coverage for the Spouse under this Plan will then be secondary to the coverage provided by the Spouse's Employer's plan. The Employee or Spouse of Employee will provide all information required to administer this provision through the initial enrollment form or through the COB Questionnaire form. Until the Claim Administrator has received all required documentation, any claims for the Spouse will be denied or returned to the sender.

To coordinate benefits, it is necessary to determine in what order the benefits of various plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede two (2) above.
4. If an individual is covered as a Dependent under two separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

If the parent with custody **has not** remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the parent without custody is secondary.

If the parent with custody **has** remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the stepparent with custody is secondary.
- c) The plan of the parent without custody is tertiary (third).

There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. When such coverage is engaged and a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.

- 5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
- 6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

If the eligible Employee or any eligible Dependent has duplicate coverage under any other “plan”, the benefits payable by this Plan will be adjusted and reduced. In this regard, this Plan is the secondary payer. This is done so that benefits payable from all sources do not exceed 100% of eligible charges (based on Reasonable & Customary) incurred.

When a Covered Person is covered primarily under another plan, the benefits paid under the primary plan will be deducted from the total covered charge, and then any appropriate Deductibles and Co-Insurance under this Plan will be applied to the remaining expenses.

Any other “plan” means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association; or any homeowner’s policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any individual or non-

group health coverage, of which the Plan Administrator is actually aware, including but not limited to a plan or policy purchased or made available through a state or federally managed Health Insurance Marketplace; or any coverage provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term “plan” shall also mean any mandatory “no-fault” automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Company has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Company should have made the payment.

NOTE: If you attempt to obtain benefits through deceit, or help someone to obtain benefits under your coverage when you know he or she is not entitled to benefits, your coverage will cease immediately, without notice.

FAMILY AND MEDICAL LEAVE ACT

It is the intent of the Plan to comply with the Family and Medical Leave Act of 1993 (the Act); however, due to the nature of SEBT's organization, compliance with the Act is the responsibility of each member School Corporation.

EMPLOYEES ON MILITARY LEAVE

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

EMPLOYER POLICIES AND PROCEDURES

Except as required under the Americans with Disabilities Act, the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Employer's policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, leave of absence, layoff, reinstatement, hire or rehire. Whether an Employee averages the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Employer.

INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

The Plan may not 1) deny a Qualified Individual participation in an Approved Clinical Trial, 2) deny (or limit or impose additional conditions on) coverage of Routine Patient Costs for items and services furnished in connection with the Approved Clinical Trial, or 3) discriminate against the Qualified Individual based on his/her participation in the Approved Clinical Trial. However, if the Plan

has a network of providers and one or more network providers is participating in an Approved Clinical Trial, the Qualified Individual must participate in the Approved Clinical Trial through such network provider if the provider will accept the Qualified Individual as a participant in the trial. This requirement to use network providers will not apply to a Qualified Individual participating in an Approved Clinical Trial that is conducted outside the state in which the Qualified Individual resides (unless the Plan does not otherwise provide out-of-network coverage generally).

The following definitions are applicable under this provision:

Qualified Individual

A Covered Person who meets the following conditions:

A. The Covered Person is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition, and

B. Either:

- The referring health care professional is a participating health care provider and has concluded that the Covered Person's participation in such trial would be appropriate, or
- The Covered Person provides medical and scientific information establishing that the Covered Person's participation in such trial would be appropriate.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following subparagraphs:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 1. The National Institutes of Health.
 2. The Centers for Disease Control and Prevention.
 3. The Agency for Health Care Research and Quality.
 4. The Centers for Medicare & Medicaid Services.
 5. A cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
 6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - a. The Department of Veterans Affairs.
 - b. The Department of Defense.
 - c. The Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Routine Patient Costs

All items and services consistent with the coverage provided by the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. However, Routine Patient Costs do not include:

- the investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Life-Threatening Disease or Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

2. Your hours of employment are reduced, or
3. Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan

Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18 month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent

of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.HealthCare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace allows you to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-

pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage.

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at

www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

PLAN CONTACT INFORMATION

If you have any questions regarding COBRA Continuation Coverage under the Plan, please contact your Plan Administrator.

PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify Hospital Admissions - call the toll-free number shown on the back of your ID card.

Key Points To Remember

The claims filing address you must use for filing all medical claims is shown on your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the employee's social security number, and the name and/or group number of the Employer.
2. A Claim Form should be completed and attached with the first charges submitted on each Covered Person, each Calendar Year. A Claim Form should also be completed for each new accident and any time the patient information has changed.
3. It is your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
4. All charges must be submitted within 15 months of the date incurred. Failure to do so will result in the denial of the charges.
5. From time to time additional information may be requested to process your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by you or your provider(s) when requested. Your failure to do so will result in the denial of the claim.
6. Urgent care claims: The Plan will defer to the attending provider regarding the decision as to whether the claim constitutes an urgent care claim. Clean urgent care claims will be determined by the Plan as soon as possible (taking into account medical exigencies), but not later than 72 hours after receipt of the claim. For incomplete or incorrectly filed urgent care claims, You will be notified of the proper procedures to follow as soon as possible but no later than 24 hours after receipt of the claim.

Filing A Hospital Claim

When a Covered Person is admitted as an Inpatient or is treated as an Outpatient, the bill will probably be directly submitted per the claims filing instructions on your ID card by the Hospital. However, it is your responsibility to verify that the bill has been

submitted and is accurate. Therefore, secure an itemized Hospital bill and check for any errors you may be able to identify. If any are found, notify Allied Benefit Systems, Inc. and they will follow up with the Hospital to be sure that any such errors are corrected.

Always retain a copy for your records

Miscellaneous Claims Filing Considerations

It is necessary to keep separate records of your expenses with respect to each of your Dependents and yourself. The following items are important and should be carefully kept to be submitted with your claim:

- 1) All Physician's bills should show the following:
 - a) Name of patient and adequate membership information
 - b) Dates and charges for services, and payment status of each
 - c) Types of service rendered and procedure codes
 - d) Diagnosis information

- 2) Prescription drug expenses (if submitted as a claim due to being Medically Necessary and not available under the Prescription Drug Card or Mail Order Programs) should show the following:
 - a) Name of patient and adequate membership information
 - b) Prescription number and name of drug
 - c) Cost of the drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment
 - d) Generic Drugs should be indicated on the drug bill

- 3) Bills for all other Covered Medical Charges, such as for ambulance service, durable medical equipment, etc. should show the following:
 - a) Name of patient and adequate membership information
 - b) Date of service
 - c) Charge and description of each service/item
 - d) Diagnosis information

Always retain a copy for your records.

SCHOOL EMPLOYEES' BENEFIT TRUST (SEBT) HEALTH BENEFIT PLAN

to comply with the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Standards”)

The School Employees' Benefit Trust (SEBT) Health Benefit Plan (the “Plan”) Plan Document and Summary Plan Description (the “Plan Documents”) are hereby amended to comply with HIPAA’s Privacy Standards, as follows:

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI 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 PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

- SEBT Chairman or his designee
 - School Administrative Personnel
 - SEBT Privacy Officer

- ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” functions are activities that would meet the definitions of treatment, payment and health care operations. “Plan Administration” functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, medical necessity reviews, appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT COVERED PERSONS MAY BE USED AND DISCLOSED AND HOW COVERED PERSONS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (“Notice”) describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan’s legal obligations concerning a Covered Person’s protected health information and describes a Covered Person’s rights to access, amend and manage that protected health information.

Protected health information (“PHI”) is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person’s past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

This Notice has been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact:

Board of Trustees, School Employees’ Benefit Trust,
805 East Harrison Street Bluffton, IN 46714

THE PLAN’S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Covered Person’s PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan’s legal duties and of its privacy practices with respect to the Covered Person’s PHI, abide by the terms of the Notice that is currently in effect, and notify the Covered Person in the event of a breach of the Covered Person’s unsecured PHI. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for

all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

TREATMENT

The Plan will use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related

services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician.

PAYMENT

The Plan will use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

HEALTH CARE OPERATIONS

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

REQUIRED BY LAW

The Plan may use or disclose PHI to the extent the law

requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

PUBLIC HEALTH ACTIVITIES

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Person’s PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

LEGAL PROCEEDINGS

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

LAW ENFORCEMENT

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION ORGANIZATIONS

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

RESEARCH

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

INMATES

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

WORKERS' COMPENSATION

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

EMERGENCY SITUATIONS

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

FUNDRAISING ACTIVITIES

The Plan may use or disclose the PHI of a Covered Person for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

GROUP HEALTH PLAN DISCLOSURES

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person. The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

UNDERWRITING PURPOSES

The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or

disclosing in the underwriting process the PHI of the Covered Person that is genetic information.

OTHERS INVOLVED IN YOUR HEALTH CARE

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

OTHER COVERED ENTITIES

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary

health information” to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON’S AUTHORIZATION

SALE OF PHI

The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person’s PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

MARKETING

The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person’s PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person or when the Plan provides promotional gifts of nominal value.

PSYCHOTHERAPY NOTES

The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person’s psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person’s written authorization. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A COVERED PERSON’S RIGHTS

The following is a description of a Covered Person’s rights with respect to PHI:

RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on

the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

RIGHT TO INSPECT AND COPY

A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

RIGHT TO AMEND

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

RIGHT OF AN ACCOUNTING

The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Person may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

RIGHT TO A COPY OF THIS NOTICE

The Covered Person has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. If you receive this Notice on the Plan's website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A copy of a complaint form is available from this contact office.

A Covered Person also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Person became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “SECURITY STANDARDS”)

1. Definitions

- a. The term “Electronic Protected Health Information” (“EPHI”) has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.
- b. The term “Security Incidents” has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. Plan Sponsor Obligations

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and

- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and
 - ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.
- e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Office of the Company. The Company has retained the services of an independent Claims Processor experienced in claims processing (Allied Benefit Systems, Inc). Fiscal records are maintained for a Plan Year ending as of the last day of December each year.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon the Plan Administrator, **Board of Trustees, School Employees' Benefit Trust**, 805 East Harrison Street Bluffton, IN 46714.

APPEALING A CLAIM

CLAIMS PROCEDURES

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An Adverse Benefit Determination is subject to the provisions detailed below.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.

- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, and the contact information for the Employee Benefits Security Administration (1-866-444-EBSA (3272)) to assist individuals with the first, second and third (external) level claim and appeal processes (the third if applicable, see below).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination 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 the claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

FIRST LEVEL APPEALS PROCEDURE

If you receive an Adverse Benefit Determination, you or your authorized representative may appeal the determination by filing a written application with the Plan Administrator, through Allied Benefit Systems, Inc., the Claims Processor. In appealing an Adverse Benefit Determination, the Plan Administrator will provide you or your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.

- A full and fair review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give you a reasonable opportunity to respond prior to that date.
- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination 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, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received. The Plan Administrator will notify you or your authorized representative of its determination within 60 days after receipt of an appeal. The Plan Administrator's determination:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their

meaning, as well as the Plan's standard used in denying the claim.

- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain 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 the claim for benefits.
- Will contain a description of the Plan's second and third level (external) review processes, including information on how to initiate a second and third level appeal, and the contact information for the Employee Benefits Security Administration to assist individuals with the second and third level review processes (1-866-444-EBSA (3272)). The third level review process is applicable solely where the Plan's underlying determination involved 1) a rescission of coverage or 2) medical judgment).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination 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 the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, you are deemed to have exhausted the first level claims and appeals process (unless the Plan's failure to strictly adhere to these requirements is 1) *de minimis*, 2) non-prejudicial, 3) attributable to good cause or matters beyond the Plan's control, 4) in the context of an ongoing good faith exchange of information, and 5) not reflective of a pattern or practice of non-compliance). Accordingly, upon such a failure, you may directly bypass the second level, and initiate a third level (external) review (see below), or if not applicable, pursue any available remedies under applicable law.

To the extent the Plan contends that it did not commit a procedural violation based on the five criteria referenced immediately above, you will be entitled, upon written request, to an explanation of the Plan's basis for such an assertion (to be provided within ten days), so that you can make an informed judgment about whether to seek immediate review from an external reviewer if applicable, or, if not applicable, a court of law. Finally, if the external reviewer or the court of law (as applicable) rejects your request for immediate review on the basis that the Plan did not engage in a violation, you have the right to resubmit and pursue the first level claims and appeals process.

SECOND LEVEL APPEALS PROCEDURE

If you are not satisfied with the Plan Administrator's benefit determination on review of your

First Level Appeal, you may submit a written Second Level Appeal to the Claims Processor (Allied) and request that the Plan Sponsor (SEBT) review your appeal. Be sure to designate your appeal as a Second Level Appeal in writing. Be sure to say why you think the payment decision is not correct—in other words, why you think your claim should be paid. You must send this request to Allied 180 calendar days after you receive your Explanation of Benefits Form, or within 30 days after you receive the benefit determination on review of your appeal from the Plan Administrator, whichever is later.

In connection with your appeal, you have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits; and
2. Review and obtain without charge copies of documents, records and other information relevant to the claim being appealed.

The Claims Processor will send the request to a representative of the Plan Sponsor, who will then make a full and fair review of the claim, taking into account everything you have submitted. You may be requested to submit additional information to make the review.

The review and decision will be made by the Plan Sponsor at the next scheduled board meeting of the School Employees Benefit Trust (Plan Sponsor) provided the appeal and sufficient documentation is received by the Claims Processor at least 10 business days prior to the scheduled meeting. A written decision will be issued by the board following the meeting. If a decision is not issued by the board, the appeal shall be deemed denied.

You may bypass the Second Level appeal procedure and request a Third Level External Review. In such case, the Second level appeal shall be deemed denied or waived, and you may proceed under the procedure described below for the Third Level (External) Appeals Procedure.

THIRD LEVEL (EXTERNAL) APPEALS PROCEDURE

If your second level appeal is denied or waived, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or your authorized representative may file a third level (external) appeal of the Final Internal Adverse Benefit Determination by filing a written application with the Plan Administrator, through Allied Benefit Systems, Inc., the Claims Processor, where the Plan's underlying determination involved 1) a rescission of coverage or 2) medical judgment.

A third level appeal must be filed within 4 months after the Final Internal Adverse Benefit Determination is received. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Plan reserves the right to charge a nominal filing fee, as allowed by applicable law.

Preliminary review. Within 5 business days following the date of receipt of the third level (external) review request, the Plan must complete a preliminary review of the request to determine whether:

- a. The claimant is or was covered under the Plan at the time the health care service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care service was provided;
- b. The Plan's underlying determination involved 1) a rescission of coverage or 2) medical judgment;
- c. The claimant has exhausted the Plan's first and second level appeal processes; and
- d. The claimant has provided all the information and forms required to process a third level review.

Within one business day after completion of the preliminary review, the Plan must issue a notification in writing to the claimant. If the request is complete but not eligible for a third level review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the Plan must allow a claimant to perfect the request for the third level review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization. The Plan must assign an independent review organization ("IRO") to conduct the

third level (external) review. The assigned IRO will timely notify the claimant in writing of the acceptance for the third level review. This notice will include a statement that the claimant may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the third level review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Plan fails to timely provide the documents and information, the IRO may terminate the third level review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Final Internal Adverse Benefit Determination that is the subject of the third level review. The third level review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the IRO. The IRO must terminate the third level review upon receipt of the notice from the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim without deference to the Plan and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider the following additional information:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from other health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by the Plan, unless such criteria are inconsistent with the terms of the Plan or applicable law; and
- The opinion of the IRO's clinical reviewer(s) to the extent the information or documents are available and the clinical reviewer(s) considers appropriate;

The IRO must provide written notice of its third level review decision within 45 days after it receives the request for the third level review. The notice must be provided to both the claimant and the Plan, and must include the following:

- A general description of the reason for the request for the review with enough information to identify the claim, and reason for the Final Internal Adverse Benefit Determination;
- The date the IRO received the assignment to conduct the third level review;
- The date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards used;
- A statement that the determination is binding, except to the extent other legal remedies may be available under Federal or state law to the Plan or claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

The IRO must maintain records of all claims and notices associated with the third level review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

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

For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

ASSIGNMENT OF BENEFITS

The Plan will use its best efforts to recognize assignments of benefits from providers of services but is not bound by such assignments. When payment is made directly to the Covered Person (with or without an assignment), it is solely the responsibility of the Covered Person to reimburse the provider.

COMPLIANCE

The intent of the Plan is to assure full compliance with all appropriate laws, rules and regulations, and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional.

CONTRIBUTIONS

The benefits provided under the terms of this Plan are purchased through Employer contributions. At the discretion of the Company, Employees may be required to contribute on a payroll deduction basis.

FUNDING

This Plan is a Company sponsored self-funded medical and prescription drug reimbursement program. The Company has purchased specific and aggregate, stop-loss reinsurance coverage.

LIENS

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Company and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

PLAN AMENDMENT, MODIFICATION OR TERMINATION

The Company reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Company. Any such changes to

the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

REIMBURSEMENT AND SUBROGATION PROVISION

If a Covered Person is injured through the act or omission of another person or entity, the benefits of this Plan shall be provided only if the Covered Employee and/or covered individual shall provide a reimbursement agreement in writing.

The Plan is subrogated to the right of recovery for eligible expenses payable by the Plan, which are a result of Injuries or Illness suffered from an incident or the negligent conduct of a third party and which are payable in part or in whole by such third party, another person, an insurance company, or from a judgment or settlement.

In addition, the Plan is subrogated to the right of recovery for any expenses paid, which are the result of a work-related Injury and which are payable in part or in whole by any third party, any insurance company, or from any judgment, settlement or award relating to such Injury.

The Covered Person and his executors, administrators, parents, guardians and assigns are required to reimburse the Plan to the extent of benefits provided, immediately upon collection of damages by him, whether by legal action, settlement or otherwise, and to provide the Plan with a lien and order directing reimbursement of medical payments, to the extent of benefits provided by the Plan. The lien and order may be filed with the person whose act caused the injuries, his agent or carrier, the court, or the attorney of the Covered Person.

Payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan. A representative of the Plan shall have the right, but is not required, to intervene in any suit or other proceeding to protect the reimbursement rights hereunder. A representative of the Plan shall have the right to initiate and maintain an action against responsible parties to pursue the reimbursement rights described herein if, in their discretion, the Covered Person is not pursuing or protecting those interests.

This Plan will not be liable or responsible for payment of any attorney's fees or court costs incurred in connection with the recovery of any sums by the Covered Person. The Covered Person shall be solely responsible for all fees and costs of the attorney handling the claim against the third party. A representative of the Plan shall have the right to initiate and maintain an action against responsible parties to pursue the reimbursement rights described herein if, in their discretion, the Covered Person is not pursuing or protecting those interests.

RIGHT TO RECEIVE AND RELEASE NECESSARY 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 acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Plan Supervisor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

SUBMISSION OF CLAIM

All charges should be submitted within 90 days of incurred date and, in all cases, **must** be submitted no later than 15 months from the date incurred. Failure to do the latter will result in the denial of the charges.

SUMMARY DESCRIPTION

The Company will issue to each Employee under the Plan, an individual booklet that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is that summary description.

SYSTEM FOR PROCESSING CLAIMS

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then; Reasonable and Customary charge limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

The coverage offered under this Plan by the School Employees Benefit Trust (SEBT) is subject to the rules governing Multiple Employer Welfare Arrangements (MEWAs). A MEWA may not be subject to all of the insurance laws and regulations of Indiana. State insurance guarantee funds are not available for your Multiple Employer Welfare Arrangement. If a MEWA is terminated for any reason, the trust may not be dissolved until all outstanding financial obligations of the MEWA are paid. The MEWA may retain sufficient funds to provide coverage for an additional period as the trustees of the MEWA consider prudent. The trustees may purchase additional insurance for protection against potential future claims. Any funds remaining in the MEWA after satisfaction of all obligations must be paid to participating employers or covered employees in an equitable manner meeting with the approval of the commissioner. Written notice of the termination must be provided to each covered employee, the United States Department of Labor, and the commissioner at least thirty (30) days before the effective date of the termination.

- e. The liability of each employer participant for the obligations of the MEWA is joint and several.
- f. Each employer participant has a contingent assessment liability for payment of actual losses and expenses incurred while the participation agreement was in force.
- g. Each participation agreement or contract issued by the MEWA must contain a statement of the contingent liability of employer participants. Both the application for participation and the participation agreement must contain, in contrasting color and not less than twelve (12) point type, the statement, "This is a fully assessable contract. In the event (the MEWA) is unable to pay its obligations, participating employers will be required to contribute through an equitable assessment the money necessary to meet any unfulfilled obligations."
- h. A MEWA shall provide to each participating employer the written notice, "In the event the plan or the MEWA does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the participating employer may be liable for those expenses."

- i. Every application and coverage form, including certificates of coverage, must contain in not less than twelve (12) point type the notice, “Your coverage is issued by a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for your multiple employer welfare arrangement.”

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan. The Plan Supervisor shall be fully discharged from liability under this Plan. Should any part of this benefit booklet be declared invalid, any remaining portion shall remain in full force and effect as if this benefit booklet did not contain the invalid provision.