PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

HEART OF ILLINOIS EDUCATORS ASSOCIATION
HEALTH BENEFIT PLAN

HEART OF ILLINOIS EDUCATORS ASSOCIATION
HEALTH BENEFIT PLAN

TABLE OF CONTENTS

INTRODUCTION

The Heart of Illinois Educators Association Health Benefit Plan is a self-funded health benefit plan established to provide hospital and medical benefits for employees of the following school districts, hereinafter known as the Heart of Illinois Educators Association ("Employer"):

District 50 Schools
Central-Columbia Grade School District #51
Washington Grade School District #52

This Plan represents the efforts of the Heart of Illinois Educators Association to provide employees and their dependents with the best possible health benefits at an affordable cost.

This booklet provides you with a summary of all major benefit provisions in the Plan, your rights under federal law, how you establish and/or lose eligibility, and how to appeal if a claim is not handled satisfactorily. Thus we are asking you to review this booklet and familiarize yourself with the rules and requirements and the benefits to which you may be entitled.

In reviewing this booklet, you will note that a number of terms and phrases are capitalized. This usually means that there is a definition of these terms contained in the "Definitions" Section of the Plan. It will be helpful to refer to these definitions as you review your benefits.

If you would like to contact the Contract Administrator, you may do so between 8:30 a.m. and 5:00 p.m., Central Time, Monday through Friday, using the telephone number listed on the General Information page. The Contract Administrator will assist you in determining your rights and benefits available under the Plan.

Any information that you obtain over the phone in this manner concerning your rights and benefits may not be relied upon as a guarantee of your rights, or that benefits will be paid in that manner. The availability of benefits is determined solely on the basis of the terms of the Plan as contained in this booklet. A final determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Contract Administrator and your claim is fully adjudicated.

NOTICES

Grandfathered Plan Status

The Plan is not a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). Non-grandfathered health plans must comply with certain consumer protections under Health Care Reform such as the elimination of lifetime limits on benefits and coverage of Dependent children to age 26 years. The Dental and Vision benefits are not subject to the Health Care Reform provisions.

Notification of Plan Administrator

It is the Covered Person's or Covered Dependent's responsibility to notify the Employer or Plan Administrator within 30 days of any event which would cause such person or a family member to (i) gain or lose eligibility for coverage under the Plan, (ii) become eligible for or entitled to any Plan benefit, or (iii) lose eligibility for or entitlement to any Plan benefit unless the Plan elsewhere specifically provides for a longer notice provision. The foregoing includes, but is not limited to, the following:

- notifying the Plan Administrator of an address change within 30 days of such change; and
- notifying the Plan Administrator of a name change within 30 days of such change.

Newborns and Mothers Health Protection Act of 1996

Group health plans generally may not, under federal law, 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 Caesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) and taking into consideration the availability of a post-discharge visit within 48 hours following the discharge, with either a Physician in his office or with an R.N., or L.P.N. supervised by an R.N., in the child's home.

Women's Health and Cancer Rights Act of 1998

Federal law requires this Plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other Plan terms and limitations.

GENERAL INFORMATION

The following information, together with the information contained in this booklet, comprise the Master Plan and SUMMARY PLAN DESCRIPTION of the Plan.

A. Name of Plan:

Heart of Illinois Educators Association Health Benefit Plan

B. Name and Address of Plan Sponsor and Plan Administrator:

Heart of Illinois Educators Association
100 Hillcrest Drive
Washington, IL 61571

C. Employer Identification Number (EIN): 36-4065535

D. Plan Number: 501

E. Type of Plan:

Welfare benefit plan providing medical, dental, prescription drug and vision benefits.

F. Name and Address of Named Fiduciary:

Heart of Illinois Educators Association
100 Hillcrest Drive
Washington, IL 61571

G. Name, Address, Telephone Number and E-mail Address of Contract Administrator:

HCH Administration, Inc.
P.O. Box 1986
Peoria, IL 61656-1986
1-866-679-0837
e-mail: customerservice@hchadmin.com

H. Name and Telephone Number of Utilization Review Administrator:

The Utilization Review Program is conducted by a designee of the Contract Administrator and all inquiries may be directed to the following telephone number: 866-679-0837.

I. Name, Address and Telephone Number of COBRA Notice Coordinator:

HCH Administration, Inc.
COBRA Unit
P.O. Box 1986
Peoria, IL 61656-1986
1-866-679-0837

J. Name, Address and Telephone Number of Creditable Coverage Certificate Issuer:

HCH Administration, Inc.
P.O. Box 1986
Peoria, IL 61656-1986
1-866-679-0837

K. Name and Telephone Number of Preferred Provider Organization (PPO):

Health Alliance PPO Network
1-800-447-3227
www.hchadmin.com

L. Name and Telephone Number of Pharmacy Benefit Manager:

Catalyst Rx®
1-800-997-3784
www.catalystrx.com

M. Name, Address and Telephone Number of Agent for Service of Legal Process:

William H. Campbell
Davis & Campbell, L.L.C.
401 Main Street, Ste. 1600
Peoria, IL 61602
1-309-673-1681

Note: Service of legal process may also be made upon the Plan Sponsor, the Plan Administrator or the Contract Administrator.

N. Sources of Contributions to the Plan:

The cost of providing benefits under the Plan is shared by the school districts and the Plan participants. A schedule will be distributed periodically, setting forth the current cost of benefits and the amount of those costs that are paid by the Employees.

O. Accounting:

The Contract Administrator maintains the financial records for the Plan.

P. Fiscal Year of the Plan:

July 1 through June 30

Q: Effective Date of the Plan:

March 1, 1996

R. Plan Year:

July 1 through June 30

S. Effective Date of Plan Restatement:

July 1, 2011

SCHEDULE OF BENEFITS

IMPORTANT: Please refer to the benefits section for important information regarding each service, including precertification requirements and penalties, deductible and out-of-pocket maximum application, and Preferred Providers, if applicable. Failure to comply with Plan requirements may result in a reduction or denial of benefits.

Expenses Incurred as a result of services rendered by a Non-Preferred Provider are subject to Reasonable and Customary determination provisions. Expenses Incurred rendered by a Preferred Provider are not subject to Reasonable and Customary.

Services obtained from a Non-Preferred pathologist, anesthesiologist, radiologist or emergency room Physician will be considered to be provided by the Preferred Provider if the services are rendered as part of treatment rendered at a Preferred Provider Hospital.

For purposes of this Schedule of Benefits, the term "Lifetime" refers to the time a person is actually a Covered Person of any welfare benefit plan options (detailed herein or in another plan document or SPD bearing the same Plan number) sponsored by the Employer, and is not intended to suggest benefits beyond an individual's termination date.

CAUTION: The Preferred Provider Organization is subject to change from time to time. It is the Claimant's/Employee's responsibility to verify that a provider is participating as a Preferred Provider at the time charges are incurred.

MEDICAL BENEFITS

	PREFERRED PROVIDER AND OUT-OF-AREA[1]		**NON-PREFERRED PROVIDER**	
	Effective 7/1/2011	**Effective 7/1/2012**	**Effective 7/1/2011**	**Effective 7/1/2012**
LIFETIME MAXIMUMS, PER PERSON				
Individual Lifetime Maximum[2]	Unlimited			
Substance Abuse – Inpatient Treatment[2]	$25,000			
CALENDAR YEAR MAXIMUM BENEFITS, PER PERSON				
Chiropractic Treatment (includes acupuncture)	30 visits			
Home Health Care	120 days/visits			
Mental Illness – Inpatient Treatment	30 days/visits			
Mental Illness – Office Visits and Outpatient Treatment	60 days/visits			
Substance Abuse – Office Visits and Outpatient Treatment	$60 per visit; limited to 50 visits per Calendar Year			
PLAN YEAR MAXIMUM BENEFITS, PER PERSON				
Autism Spectrum Disorder (benefits are available to Plan participants age 21 years and under)[2]	$38,527	To be determined	$38,527	To be determined
ESSENTIAL HEALTH BENEFITS MAXIMUM (July 1 – June 30)				
Individual Essential Health Benefits Maximum[2]	$5,000,000			

	PREFERRED PROVIDER AND OUT-OF-AREA[1]		NON-PREFERRED PROVIDER	
	Effective 7/1/2011	**Effective 7/1/2012**	**Effective 7/1/2011**	**Effective 7/1/2012**
DEDUCTIBLE, PER CALENDAR YEAR				
Per Person	$350	$500	$1,500	$1,500
Per Family Unit (all family members combined)	$700	$1,000	$3,000	$3,000

The Calendar Year deductible does not apply to the following services:

- Hospital Satellite Urgent Care Clinic
- Outpatient Emergency Room
- Outpatient Pre-Admission Testing
- Routine Preventive Care
- Second Surgical Opinions
- Supplemental Accident Benefit, up to $300

The same expenses apply to satisfy both the Preferred Provider and Non-Preferred Provider maximums.

MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR				
Per Person (including deductible)	$1,050	$1,500	$3,000	$3,000
Per Family Unit (including deductible; all family members combined)	$2,100	$3,000	$6,000	$6,000

The Preferred Provider and Non-Preferred Provider deductible and out-of-pocket maximums are calculated on a combined basis.

After the Calendar Year deductible is met, the Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year. The following do not track toward your out-of-pocket limit:

- Copayments
- Outpatient Mental Illness/Substance Abuse
- Plan Exclusions

COVERED SERVICES	PREFERRED PROVIDER AND OUT-OF-AREA[1]		NON-PREFERRED PROVIDER	
	Effective 7/1/2011	**Effective 7/1/2012**	**Effective 7/1/2011**	**Effective 7/1/2012**
Routine Preventive Care (includes all services listed under Addendum B – "Be Healthy Using Your Preventive Care Benefits")	100%; Deductible waived		Deductible, then 60%	
Hospital Services				
Room and Board (semi-private)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Intensive Care Unit or Cardiac Care Unit	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Other Inpatient	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Outpatient Surgery and Diagnostic Services (includes Ambulatory Surgical Facility)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Outpatient Pre-Admission Testing	100%; Deductible waived		100%; Deductible waived	

	PREFERRED PROVIDER AND OUT-OF-AREA[1]		NON-PREFERRED PROVIDER	
	Effective 7/1/2011	**Effective 7/1/2012**	**Effective 7/1/2011**	**Effective 7/1/2012**
Outpatient Emergency Room (includes Urgent Care Room in the Emergency Room)	$150 Copayment, then 85%; Deductible waived	$150 Copayment, then 80%; Deductible waived	$150 Copayment, then 85%; Deductible waived	$150 Copayment, then 80%; Deductible waived
Hospital Satellite Urgent Care Clinic	$30 Copayment, then 100%; Deductible waived		Deductible, then 60%	
Inpatient Rehabilitation Facility	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Skilled Nursing Facility (limited to 60 days per Sickness or Injury)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Physician Services				
Inpatient visits	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Office visits (includes Nurse Practitioners and Physician's Assistants)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Labs and X-rays	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Office Surgery	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Other Surgery	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Second Surgical Opinions	100%; Deductible waived		100%; Deductible waived	
Allergy Treatments	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Ambulance Service	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Cardiac Rehabilitation (Phases I and II only)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Chemotherapy – Outpatient **Radiation Treatment – Outpatient**	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Chiropractic Treatment (includes acupuncture) – limited to 30 visits per Calendar Year maximum	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Diabetes Self-Management Training and Education (limited to 3 visits upon initial diagnosis of diabetes; limited to 2 visits upon a determination that a significant change in the patient's symptoms or medical condition has occurred)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Durable Medical Equipment	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Genetic Testing	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Home Health Care (limited to 120 days/visits per Calendar Year maximum)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Hospice Care (bereavement counseling limited to 6 sessions in a 12 month period)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Kidney Dialysis – Outpatient	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	

	PREFERRED PROVIDER AND OUT-OF-AREA[1]		NON-PREFERRED PROVIDER	
	Effective 7/1/2011	**Effective 7/1/2012**	**Effective 7/1/2011**	**Effective 7/1/2012**
Maternity	Same as any Sickness		Same as any Sickness	
Birthing Center	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Medical Supplies	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Mental Illness/Substance Abuse				
Mental Illness – Office Visits and Outpatient Treatment (limited to 60 days/visits per Calendar Year maximum	50%		50%	
Mental Illness – Inpatient Treatment (Partial Hospitalization : two days equals one day Inpatient) – limited to 30 days/visits per Calendar Year maximum	85%		80%	
Substance Abuse – Office Visits and Outpatient Treatment (limited to $60 per visit and further limited to 50 visits per Calendar Year maximum)	Deductible, then 50%		Deductible, then 50%	
Substance Abuse – Inpatient Treatment (Partial Hospitalization : two days equals one day Inpatient) – limited to 30 days/visits per Calendar Year maximum and further limited to $25,000 per Lifetime maximum[2]	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Autism Spectrum Disorders (benefits are available to Plan participants age 21 years and under)[2]	Deductible, then 85%; (limited to $38,527 per Plan Year maximum)	Deductible, then 80% (limitation maximum to be determined)	Deductible, then 60%; (limited to $38,527 per Plan Year maximum)	Deductible, then 60% (limitation maximum to be determined)
Oral Surgery	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Organ Transplants[2, 3]	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Private-Duty Nursing	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Prosthetics	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Supplemental Accident Benefit	100%; Deductible waived up to $300, then same as any other Illness		100%; Deductible waived up to $300, then same as any other Illness	
Telephone Consultation	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Temporomandibular Joint (TMJ) Dysfunction (Phases I and II combined)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
Therapy (Occupational; Physical; Respiratory; Speech)	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	
All Other Covered Services[4]	Deductible, then 85%	Deductible, then 80%	Deductible, then 60%	

	PREFERRED PROVIDER AND OUT-OF-AREA[1]		NON-PREFERRED PROVIDER	
	Effective 7/1/2011	**Effective 7/1/2012**	**Effective 7/1/2011**	**Effective 7/1/2012**
Utilization Review Penalty	Lesser of (i) eligible charges, or (ii) $500		Lesser of (i) eligible charges, or (ii) $500	

[1] A Covered Person or Covered Dependent will be considered "Out-of-Area" if that person resides outside of a 75-mile radius of the Covered Person's place of employment with the Employer.

[2] Non-essential health benefits do not apply toward the Essential Health Benefits Maximum. Non-essential health benefits may be subject to a separate Calendar Year or Lifetime maximum amount as noted.

[3] Organ procurement from a non-living donor is limited to $10,000 per transplant. Organ procurement from a living donor is limited to $25,000 per transplant. Transportation, lodging and meals are limited to $200 per day and further limited to $10,000 per transplant.

[4] Except with respect to dental and vision benefits described in the Dental and Vision Benefits Sections.

UTILIZATION REVIEW

The Utilization Review Administrator must be notified prior to elective admission to the Hospital or within 48 hours after admission for Emergency Services or obstetric care. Failure to do so may result in a penalty in the form of a reduction in benefits otherwise computed. The reduction shall be the lesser of (i) eligible charges, or (ii) $500.

PRESCRIPTION DRUG CARD BENEFITS

PRESCRIPTION DRUG BENEFITS	COPAYMENT AMOUNT[1]
Pharmacy (30-day supply)	
Generic drugs	$7
Formulary drugs	20% Copayment to a maximum of $50
Non-formulary drugs	20% Copayment to a maximum of $75
Mail-Order (90-day supply)	
Generic drugs	$14
Brand-name formulary drugs	20% Copayment to a maximum of $100
Brand-name non-formulary drugs	20% Copayment to a maximum of $150

[1] Copayment expenses do not apply to the deductible or out-of-pocket Maximums.

DENTAL BENEFITS

CALENDAR YEAR MAXIMUM, PER PERSON (Preventive, Basic and Major Services combined)	$1,000
DEDUCTIBLE	
Preventive Services	
Per Individual	$0
Per Family Unit	$0
Basic and Major Services	
Per Individual	$50
Per Family Unit	Three individual limits

COVERED SERVICES	
Preventive Services	100%; Deductible waived
Routine oral examinations, per Calendar Year maximum	Limited to one every six months per Covered Person or Covered Dependent
Topical fluoride application, per Calendar Year maximum	Limited to one per Covered Dependent up to age 19 years
Cleaning and scaling of teeth, per Calendar Year maximum	Limited to one every six months per Covered Person or Covered Dependent
Sealants, per Lifetime maximum	Limited to unrestored permanent molars of Covered Dependents under age 16 years; limited to two treatments per tooth
Full mouth X-ray, per Calendar Year maximum	Limited to one per Covered Person or Covered Dependent
Bitewing X-ray, per Calendar Year maximum	Limited to one every six months
Basic Services	Deductible, then 85%
Major Services	Deductible, then 50%
Orthodontic Services (limited to Covered Dependents under age 19 years)	Deductible then 50%
Orthodontic Services Lifetime Maximum	$750
Orthodontic Services Deductible	$50 per person per Lifetime

VISION BENEFITS

BENEFITS	
Eye Examination (limited to one exam every 24 months per Covered Person or Covered Dependent)	100% up to a maximum benefit of $30
Frames (limited to one set of frames every 24 months per Covered Person or Covered Dependent)	100% up to a maximum benefit of $20
Lenses (limited to two lenses {one pair} every 24 months per Covered Person or Covered Dependent)	
Single Vision	100% up to a maximum benefit of $25
Bifocal Vision	100% up to a maximum benefit of $40
Trifocal Vision	100% up to a maximum benefit of $50
Lenticular	100% up to a maximum benefit of $75
Contact Lenses (see the "Benefits, Limitations, Vision Benefits" Section of the Plan for specifications)	
Medically Necessary Contact Lenses (per pair)	100% up to a maximum benefit of $150
Other Contact Lenses (per pair)	100% up to a maximum benefit of $45

This Schedule is a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations.

EMPLOYEE ELIGIBILITY

Eligibility Requirements

Each Employee and that Employee's Eligible Dependents shall be eligible to participate in the Plan on the first Eligibility Date following attainment of status as a Full-Time Employee. An Employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage becoming effective.

An Employee must enroll in the Plan within 30 days of his initial Eligibility Date, during any open enrollment period established by the Employer or during an Employee Special Enrollment Period to obtain coverage under the Plan. An Employee is not eligible to enroll in the Plan at any other time.

Eligibility Date

An Employee shall be eligible for coverage under the Plan on his or her first scheduled working date ("Eligibility Date"), provided he or she satisfies the Eligibility Requirements outlined above and applies for coverage within 30 days of such Eligibility Date.

An Employee who applies for coverage during any open enrollment period established by the Employer shall be eligible for coverage on the date established by the Employer. An Employee who applies for coverage during an Employee Special Enrollment Period shall be eligible for coverage on the date of the event precipitating the Employee Special Enrollment Period.

Employee Special Enrollment Periods

An Employee who did not enroll in the Plan on his or her initial Eligibility Date may also enroll in the Plan during an Employee Special Enrollment Period provided the Employee was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to the Employee, and, if required by the Employer, the Employee submitted a written statement to the Plan Administrator (at the time coverage was offered) that the other health coverage was the reason for declining enrollment. Unless otherwise stated, an "Employee Special Enrollment Period" shall be the 30-day period immediately following one of the events described below:

A. Loss of Other Coverage

For purposes of these rules, a loss of other coverage occurs if:

1. the Employee exhausted coverage under a COBRA continuation provision of a group health plan; or the termination of coverage under another group health plan as a result of loss of eligibility for such coverage; or the termination of employer contributions toward such coverage;

2. the Employee has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g., part-time Employees);

3. the Employee has a loss of eligibility as a result of legal separation, divorce, dissolution of a Civil Union, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment or reduction in the number of hours of employment, or termination of employer contributions toward the coverage;

4. the Employee has a loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside or work in the service area, whether or not within the choice of the individual;

5. the Employee has a loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside or work in a service area, whether or not within the choice of the individual, and no other benefit package is available to the individual;

6. the Employee has a loss of eligibility as a result of his or her involuntary loss of coverage under a Medicaid plan under Title XIX of the Social Security Act, or under a State Child Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. A request for enrollment must be made within 60 days of the date coverage ends (also see "Addendum C – Medicaid and the State Children's Health Insurance Program (SCHIP) Offer Free Or Low-Cost Health Coverage To Children And Families");

If the Employee lost the other coverage as a result of his or her failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), the Employee does not have a Special Enrollment right.

The Employee will be eligible for coverage on the date following the date of loss of other coverage. Unless otherwise noted, the Employer must receive the Employee's completed application within 30 days of the loss of coverage.

B. Dependent Special Enrollment Period

If an Employee is a participant under this Plan (or has met the waiting period applicable to becoming a participant under the Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period) and a person becomes an Eligible Dependent of the Employee through marriage, Civil Union, birth, adoption or placement for adoption, then the Eligible Dependent and, if not otherwise enrolled, the Employee, may be enrolled under this Plan. (See "Eligible Dependent" in the "Definitions" section.)

1. In the event of marriage, the Employee, his or her spouse and any Dependent children who are newly acquired as the result of the marriage may enroll, provided they meet the definition of an Eligible Dependent as outlined in the "Definitions" section. In this instance, any eligible Dependent children who were not enrolled when initially eligible or during any open enrollment period established by the Employer are permitted to enroll. Coverage will be effective on the date of the marriage.

2. In the event of a Civil Union, the Employee, his or her Civil Union Partner and any Dependent children newly acquired as the result of the Civil Union may enroll, provided they meet the definition of an "Eligible Dependent" as described in the "Definitions" section. In this instance, any Eligible Dependent children who were not enrolled when initially eligible or during any open enrollment period established by the Employer are permitted to enroll. Coverage will be effective on the date of the Civil Union.

3. In the event of the birth of a child of the Employee, the Employee, his or her eligible spouse/Civil Union Partner and the newborn child may enroll. Coverage will be effective on the date of birth.

4. In the event of the adoption of a child by the Employee or the placement of a child in the home of the Employee while adoption proceedings are pending with respect to that child, the Employee, his or her eligible spouse/Civil Union Partner and the adopted child or child placed for adoption may enroll. Coverage will be effective on the date of adoption or placement for adoption.

The Employee may only enroll for coverage during a Dependent Special Enrollment Period if the Dependent described in subsection (1), (2), (3) or (4) is also enrolled in the Plan during the 30-day period described above.

C. Premium Assistance Program (also see "Addendum C – Medicaid and the State Children's Health Insurance Program (SCHIP) Offer Free Or Low-Cost Health Coverage To Children And Families")

If an Employee becomes eligible for premium assistance through Medicaid or a State Child Health Insurance Program (SCHIP), he or she may have a right to enroll in this Plan. A request for enrollment must be made within 60 days of the date the Employee is determined eligible for such assistance. Contact the Plan Administrator for additional information regarding this provision.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective on the date of the event precipitating the Employee Special Enrollment Period.

DEPENDENT ELIGIBILITY

Eligibility for Dependent's Coverage

A Covered Person may obtain benefits for his or her Eligible Dependents under the Plan on:

A. The date the Covered Person is eligible for coverage under the Plan, if on that date he or she has such Eligible Dependents; or

B. The date the Covered Person gains an Eligible Dependent, if on that date he or she is covered by the Plan.

C. Eligible Dependent children may enroll annually prior to the beginning of a Plan Year. Coverage will be effective July 1 provided the enrollment application is completed prior to the effective date. Employees will receive from their Employer detailed information regarding any requirement or enrollment time period information needed to make an informed decision.

An Employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage for an Eligible Dependent becoming effective.

In the event two parents are both eligible to be covered by the Plan as Covered Persons, only one parent will be eligible to cover any Eligible Dependent children they might have.

If both parents are covered Employees and the parent carrying dependent coverage under the Plan terminates coverage, Dependent coverage may automatically transfer to the parent who remains covered by the Plan provided the second parent continues to be a covered Employee. If both a husband and wife are covered Employees and one terminates coverage with the Plan, he or she may remain covered as a Dependent under the remaining spouse's coverage.

Eligibility Date of Dependent's Coverage

A. The Eligibility Date of coverage for each Eligible Dependent will be the later of (i) the date on which the Covered Person who is the source of a Dependent's eligibility becomes eligible for Dependent coverage or (ii) the date the Dependent becomes an Eligible Dependent, subject to the following:

1. A newborn child of a Covered Person will be considered an Eligible Dependent from the moment of birth and will be eligible for benefits for Sickness or Injury, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Covered Person within 30 days of the child's date of birth;

2. A spouse will be considered an Eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Covered Person within 30 days of the date of marriage; and

3. A Civil Union Partner will be considered an Eligible Dependent from the date of the Civil Union, provided he or she is properly enrolled as a Dependent of the Covered Person within 30 days of the date of the Civil Union.

4. A Dependent acquired other than at the time of birth due to court order, decree, marriage, Civil Union or placement in the home of the Covered Person while adoption proceedings are pending will be considered an Eligible Dependent from the date of such court order, decree, marriage, Civil Union or placement, provided that the Dependent is properly enrolled as a Dependent of the Covered Person within30 days of the date of the court order, decree, marriage, Civil Union or placement.

In situations where Dependent coverage is already in effect prior to the date a Dependent is acquired pursuant to paragraphs (1), (2) (3) or (4) above, the 30-day period described above shall be deemed to be satisfied, provided that the Employee completes the proper enrollment forms within a reasonable time after acquiring the Dependent. Although the effective date will not be delayed, no claims will be processed under the Plan until the Dependent is properly enrolled.

An Eligible Dependent must enroll in the Plan within 30 days of his or her initial Eligibility Date, during any open enrollment period established by the Employer, or during a Special Enrollment Period in order to obtain coverage under the Plan. An Eligible Dependent is not eligible to enroll in the Plan at any other time.

An Eligible Dependent who applies for coverage during any open enrollment period established by the Employer shall be eligible for coverage on the date established by the Employer. An Eligible Dependent who applies for coverage during a Special Enrollment Period shall be eligible for coverage from the date of the event precipitating the Special Enrollment Period.

In no event will the Eligibility Date for a Dependent precede the Eligibility Date for the Covered Person who determines the Dependent's eligibility for benefits under the Plan.

Special Enrollment Periods

An Eligible Dependent may also enroll in the Plan during a special enrollment period provided the Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to him or her, and if required, the Employee submitted a written statement to the Plan Administrator (at the time coverage was offered) that the other health coverage was the reason for declining enrollment. Unless otherwise stated, a "Special Enrollment Period" shall be the 30-day period immediately following one of the events described below:

A. Loss of Other Coverage

For purposes of these rules, a loss of other coverage occurs:

1. if the Eligible Dependent exhausted coverage under a COBRA continuation provision of a group health plan, or if coverage under another group health plan terminated as a result of loss of eligibility for such coverage or due to the termination of employer contributions toward such coverage;

2. if the Eligible Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time Employees);

3. if the Eligible Dependent has a loss of eligibility as a result of legal separation, divorce, dissolution of a Civil Union, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated;

4. if the Eligible Dependent has a loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside or work in the service area, whether or not within the choice of the individual;

5. if the Eligible Dependent has a loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside or work in a service area, whether or not within the choice of the individual, and no other benefit package is available to the individual;

6. if the Eligible Dependent has a loss of eligibility as a result of his or her involuntary loss of coverage under a Medicaid plan under Title XIX of the Social Security Act, or under a State Child Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. A request for enrollment must be made within 60 days of the date coverage ends (also see "Addendum C – Medicaid and the State Children's Health Insurance Program (SCHIP) Offer Free Or Low-Cost Health Coverage To Children And Families");

If the Eligible Dependent lost the other coverage as a result of his or her failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), the Dependent does not have a Special Enrollment right.

The Dependent will be eligible for coverage on the date following the date of loss of other coverage. Unless otherwise noted, a completed application must be received by the Employer within 30 days of the loss of coverage.

B. Dependent Special Enrollment Period

1. In the event of marriage to the Employee, the spouse and any Eligible Dependent children who are newly acquired as the result of the marriage may enroll, provided they satisfy the definition of an Eligible Dependent as outlined in the "Definitions" section. In this instance, any Eligible Dependent children who were not enrolled when initially eligible or during any open enrollment period established by the Employer are permitted to enroll. Coverage will be effective on the date of the marriage.

2. In the event of an Employee's Civil Union, the Civil Union Partner and any Dependent children who are newly acquired as a result of the Civil Union may enroll, provided they satisfy the definition of an "Eligible Dependent" as outlined in the "Definitions" section. In this instance, any Eligible Dependent children who were not enrolled when initially eligible or during any open enrollment period established by the Employer are permitted to enroll. Coverage will be effective on the date of the Civil Union.

3. In the event of the birth of an Eligible Dependent, the Employee, his or her spouse/Civil Union Partner and the Eligible Dependent may enroll. Coverage will be effective on the date of birth.

4. In the event of the adoption of an Eligible Dependent child by the Employee or the placement of an Eligible Dependent child in the home of the Employee while adoption proceedings are pending with respect to that child, the Employee, his or her spouse/Civil Union Partner and the Eligible Dependent child may enroll. Coverage will be effective on the date of adoption or placement for adoption.

The Eligible Dependent may only enroll for coverage during a Special Enrollment Period if the Employee is also enrolled in the Plan on or before the 30-day period described above.

C. Premium Assistance Program (also see "Addendum C – Medicaid and the State Children's Health Insurance Program (SCHIP) Offer Free Or Low-Cost Health Coverage To Children And Families")

If an Eligible Dependent becomes eligible for premium assistance through Medicaid or a State Child Health Insurance Program (SCHIP), there may be a right to enroll in this Plan. A request for enrollment must be made within 60 days of the date the Dependent is determined eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective on the date of the event precipitating the Employee Special Enrollment Period.

In no event will the Eligibility Date for a Dependent precede the Eligibility Date for the Covered Person who determines the Dependent's eligibility for benefits under the Plan.

Spouses/Civil Union Partners Eligible For Other Employer-Sponsored Health Coverage

Notwithstanding the Sections "Eligibility for Dependent Coverage," "Eligibility Date of Dependent Coverage" and "Special Enrollment Periods" above, if an Eligible Dependent spouse/Civil Union Partner is eligible for other group health coverage through another employer or union, the spouse/Civil Union Partner cannot be covered under this Plan unless such spouse/Civil Union Partner is also covered by such other group health coverage. A spouse/Civil Union Partner is considered "eligible" for other group health coverage for this purpose if the spouse/Civil Union Partner is entitled to enroll in such other group health coverage as an employee or member, or the spouse/Civil Union Partner had previously declined or refused to enroll in such other group health coverage and remains within a class of employees or members allowed to participate in such group health coverage (without regard to any enrollment restrictions applicable to late enrollees under such other group health coverage).

An Eligible Dependent spouse/Civil Union Partner for who coverage under the Plan is unavailable pursuant to the preceding paragraph shall not be allowed to enroll in the Plan until the earlier of (i) the date the spouse/Civil Union Partner is no longer eligible for such other group health coverage, or (ii) the date the spouse/Civil Union Partner provides sufficient proof to the Plan Administrator that the spouse/Civil Union Partner cannot enroll in such other group health coverage pursuant to the terms of such coverage and applicable law.

Other group health coverage described above shall not include a flexible spending arrangement under Internal Revenue Code Section 125.

OTHER ENROLLMENT OPPORTUNITIES

Enrollment of Dependent Children

An Employee may request enrollment for children whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of Dependent coverage of children ended before attainment of age 26. If not currently enrolled, the eligible Employee may also enroll. Eligible Employees will receive a notice including detailed information about this one-time enrollment opportunity from their Employer. The Employee must request enrollment for such children within 30 days of the date he or she receives the notice. Enrollment will be effective July 1, 2011. If the enrollment request is not received within the specified time frame, the child may only enroll during a Special Enrollment Period, during any open enrollment period established by the Employer or during the 30-day period prior to the beginning of a Plan Year (see the Section titled "Eligibility for Dependent's Coverage").

Exhaustion of Individual Lifetime Maximum Benefit

This Plan may no longer apply an individual Lifetime Maximum on all benefits. An Employee and/or his or her Eligible Dependents whose coverage ended by reason of reaching an individual lifetime maximum limit under the Plan are eligible to enroll in the Plan. Eligible Employees will receive a notice including detailed information about this one-time enrollment opportunity from their Employer. Employees must request enrollment within 30 days of the date he or she receives the notice. Enrollment will be effective July 1, 2011. If the enrollment request is not received within the specified time frame, the individual (an Employee and/or his or her spouse/Civil Union Partner) may only enroll during a Special Enrollment Period or during any open enrollment period established by the Employer. If the enrollment request is not received within the specified time frame, an Employee's Eligible Dependent child may only enroll during a Special Enrollment Period, during any open enrollment period established by the Employer or during the 30-day period prior to the beginning of a Plan Year (see the Section titled "Eligibility for Dependent's Coverage").

Enrollment of Civil Union Partners

A Covered Person who entered into a recognized Civil Union, as defined, in another state prior to June 1, 2011 may enroll his/her eligible Civil Union Partner and the Partner's eligible Dependent children in the Plan during the 30-day enrollment period beginning on June 1, 2011. Coverage will be effective the first day of the first month following the date the enrollment application is completed. If the enrollment application is not received within the 30-day enrollment period, the Civil Union Partner may only enroll during a Special Enrollment Period. The Civil Union Partner's eligible Dependent children may only enroll during a Special Enrollment Period, during any open enrollment period established by the Employer or during the 30-day period prior to the beginning of a Plan year (see the section titled "Eligibility for Dependent's Coverage"). Pre-Existing Conditions limitations may apply.

The Employer will provide information concerning this one-time enrollment opportunity.

BENEFITS

Limitations

A. Deductible Expenses

During each Calendar Year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the first covered Expenses Incurred as described in the Schedule of Benefits ("Deductible Expenses).

The Deductible Expenses shall be paid only once during a Calendar Year by each Covered Person or Covered Dependent, and shall be paid only once if (i) a Covered Person and one or more of his or her Covered Dependents, or (ii) two or more Covered Dependents of a Covered Person incur Injuries in the same accident.

Notwithstanding any provision in this Section to the contrary, the total Deductible Expenses to be paid by a Covered Person and his or Covered Dependents during one Calendar Year under the provisions of this Section shall not exceed the family Deductible Expense limits described in the Schedule of Benefits.

The Deductible Expenses incurred under this Section of the Plan shall not be applied to satisfy the Deductible Expense requirement under any other Section of the Plan.

B. Shared Expenses

During each Calendar Year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for a percentage of the first covered Expenses Incurred in excess of the copayment amounts as described in the Schedule of Benefits. Copayment amounts as set forth in the Schedule of Benefits do not count toward satisfaction of this limitation. Notwithstanding any provision in this Section to the contrary, the total covered Expenses Incurred (including Deductible Expenses) to be paid by a Covered Person or Covered Dependent during one Calendar Year under the provisions of this Section, and the total Shared Expenses to be paid by a Covered Person and his Covered Dependents during one Calendar Year under the provision of this Section shall not exceed the individual and family Out-of-Pocket Maximums described in the Schedule of Benefits.

C. Maximum Lifetime Benefits While Covered Under This Plan

The maximum benefit while covered under this Plan for any Covered Person or Covered Dependent shall not exceed the amount listed in the Schedule of Benefits.

D. Essential Health Benefits Maximum Amount

The Essential Health Benefits maximum amount shown in the Schedule of Benefits is the maximum amount of benefits that will be paid under the Plan for the specified time period for covered Essential Health Benefit services incurred by a Covered Person. Amounts paid for non-essential health benefits do not apply toward the Essential Health Benefits maximum, and may be subject to a separate Calendar Year or Lifetime maximum amount.

E. Pre-Existing Conditions

No benefits will be paid with respect to Expenses Incurred for a Pre-Existing Condition until the Covered Person or Covered Dependent completes 12 months from the date coverage commenced under the Plan, or, if earlier, from the first day of any required waiting period, reduced by any period of Creditable Coverage. A waiting period means the period that must pass with respect to the initial eligibility of an individual before an otherwise qualified individual may be covered under the Plan. If an individual enrolls pursuant to any open enrollment period established by the Employer, then Expenses

Incurred for a Pre-Existing Condition shall not be eligible for a period of 18 months following the date of coverage in the Plan.

The above limitation shall not apply to:

1. a Covered Person or Covered Dependent who has been continuously covered under the Plan since the Effective Date of the Plan and who was, on the day prior to such Effective Date, covered under the group plan sponsored by the Employer immediately prior to the Effective Date, to the extent he or she had satisfied a similar provision under such prior plan;

2. a Covered Person or Covered Dependent under age 19 years;

3. a Covered Person or Covered Dependent with respect to the pregnancy of such individual;

4. Expenses Incurred for outpatient prescription drug benefits paid pursuant to a separate drug card program maintained as part of the Plan.

Any period of Creditable Coverage shall be applied to reduce the Pre-Existing Condition limitation described in the Plan, except that no Creditable Coverage shall be considered if, after such Creditable Coverage, there occurs a continuous 63-day period during all of which the individual was not covered under Creditable Coverage. Any waiting period that must pass under this Plan or any other plan before the individual is initially entitled to benefits shall not be considered for the purpose of determining 63-day period. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether such 63-day period has occurred.

Periods of Creditable Coverage shall be established through presentation of certificates prepared by an individual's prior group health plan or health insurance issuer. The certificate will describe an individual's period of Creditable Coverage and any applicable waiting period that had to pass under the plan before the individual was initially entitled to benefits. A Covered Person or Covered Dependent has a right to request a Certificate of Creditable Coverage from the prior group health plan or health insurance issuer, if necessary, to properly establish the period of Creditable Coverage. The Employer will assist the Covered Person or Covered Dependent in obtaining this certificate if requested.

A Covered Person or Covered Dependent may request a certificate of Creditable Coverage from the Plan by requesting such certificate in writing from the Creditable Coverage Certificate Issuer. No certificate shall be issued by the Plan if requested more than 24 months from the date coverage under the Plan terminated.

F. Utilization Review

For treatment involving the provision of Hospital services, the Utilization Review Administrator must be notified with respect to any Covered Person or Covered Dependent (i) prior to any scheduled or non-emergency Hospital Confinement/Admission, or (ii) within 48 hours after Hospital Confinement/ Admission for Emergency Services or obstetric care.

Upon notification, the Utilization Review Administrator will review the:

- Medical Necessity for the Hospital Confinement/Admission;
- appropriateness of the place of treatment for the Sickness or Injury;
- duration of the Hospital Confinement/Admission; and
- extension, if necessary, of a previously reviewed Hospital Confinement/Admission.

The Utilization Review Administrator will advise the Covered Person or Covered Dependent as to the nature and extent of care that will be provided. If the Covered Person or Covered Dependent fails to

notify the Utilization Review Administrator as required herein, or fails to follow the instructions of the Utilization Review Administrator following notification, the benefits otherwise available under the Plan, after application of all other limitations prescribed herein, shall be further reduced by the lesser of (i) eligible charges, or (ii) the amount described in the Schedule of Benefits.

Expenses excluded in accordance with this Section shall not apply toward satisfaction of any other limitation herein.

G. Weekend Admissions

Notwithstanding any provision to the contrary, no benefits are payable under the Plan for Expenses Incurred for a Hospital Confinement/Admission if such Hospital Confinement/Admission commences during the period each week between noon on Friday and midnight on the next following Sunday. This limitation shall not apply in the case of Emergency Services or when otherwise Medically Necessary.

H. Benefits Obtained from Preferred Providers

The Employer may enter into one or more Preferred Provider Agreements with certain health care service providers from time to time. Those participating providers are designated as Preferred Providers. As a result of those agreements, covered services obtained from Preferred Providers are subject to a reduced Shared Expense limitation as described in the Schedule of Benefits. A complete listing of all Preferred Providers is available free of charge from the Employer and is subject to change at any time.

Covered services, supplies or treatments provided by a Non-Preferred Physician or at a Non-Preferred Provider facility may be reimbursed at the applicable Preferred Provider rate, as shown in the Schedule of Benefits, under the following circumstances:

a. if a Covered Person received services from a Non-Preferred Provider for a service not available in the PPO Network;

b. if a Covered Person has a Medical Emergency requiring immediate care;

c. if the service is approved in advance by the Utilization Review Administrator. The Utilization Review Administrator shall only approve the use of a non-Preferred Provider where, in the reasonable judgment of the Utilization Review Administrator, the use of the non-Preferred Provider will increase to a fair degree the likelihood of a successful medical outcome or the distance to the nearest Preferred Provider providing the service is determined to be a hardship;

d. if a Covered Person received services from a Non-Preferred Provider anesthesiologist, pathologist, radiologist or emergency room Physician(other Physicians providing one source services to Preferred Provider Hospital/Facility are also included) if the services are rendered as part of treatment at a Preferred Provider Hospital/Facility;

e. if a Covered Person received services from a non-Preferred Provider Physician if the non-Preferred Provider Physician specializes in an area or specialty in which one or less Preferred Provider Physicians practice.

Medical Benefits

Reasonable and Customary Expenses Incurred on behalf of each Covered Person or Covered Dependent are covered for:

A. Inpatient Hospital Services

1. Hospital Services:

a. Regular Room and Board (semi-private room rate);
b. Confinement in an Intensive Care Unit; and
c. Necessary Services and Supplies.

2. Skilled Nursing Facility Confinement:
   a. Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services (If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area);
   b. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private-duty or special-nursing services and Physician's fees; and
   c. Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

   A Covered Person or Covered Dependent shall be eligible for benefits under this subsection only to the extent confinement in a Skilled Nursing Facility:

   a. is certified by a Physician as essential for recuperation from the Sickness or Injury that caused such Hospital Confinement; and
   b. is not incurred for custodial care.

3. Partial Hospitalization Treatment Program:
   Treatment in a planned therapeutic treatment program of a Hospital or Substance Abuse Treatment Facility in which patients with Mental Illness or Substance Abuse spend days or nights. Each two 2 days of partial hospitalization equals one day of care for calculation of the inpatient limitations for Mental Illness/Substance Abuse treatment benefits.

B. Outpatient Services

Outpatient Treatment: Reasonable and Customary Expenses Incurred for the following Outpatient Treatment:

1. Surgery and related diagnostic service received on the same day as the Surgery, whether as Outpatient Treatment or in a Physician's office, including Physician's surgical charges;
   a. Diagnostic testing related to Surgery or Medical Care; and
   b. Services provided in an Ambulatory Surgical Facility.

2. Emergency Room Treatment: Reasonable and Customary Expenses Incurred for initial medical screening examination and Emergency Services treatment of a Sickness or Injury in a Hospital emergency room or by a Physician as required to stabilize the patient.

3. Supplemental Accident Care: Reasonable and Customary Expenses Incurred for initial Emergency Services treatment of Injury in a Hospital emergency room or by a Physician, provided, that such treatment is rendered within 90 days of the accident causing the Injury for which care is provided.

4. Pre-Admission Testing: Reasonable and Customary Expenses Incurred for pre-admission testing which is performed either:
   a. at a Hospital on an outpatient basis; or
   b. at an outpatient facility if the test results are accepted by the Hospital to which the patient is admitted;

   provided that such testing is performed within 7 days prior to admission to that Hospital on an in-patient basis for treatment in connection with the Sickness or Injury to which the pre-admission testing relates. No benefits are available pursuant to this subsection if the treatment to which the testing relates is postponed, unless such postponement is Medically Necessary.

C. Physician Services

1. Physician's services for surgical procedures performed on an inpatient basis, outpatient diagnostic services, Mental Illness and Substance Abuse treatment;

2. Office visits, house calls or visits to a Hospital or facility by a Physician;

3. Second surgical opinions and, if the second surgical opinion does not confirm the first opinion, a third opinion is also covered, and shall be considered a second surgical opinion for the purpose of this section;

4. Oral Surgery, as defined herein, including anesthesia and related charges;

5. Anesthetics and their administration by a professional anesthetist or anesthesiologist;

6. Services for voluntary sterilization or surgical reversal of voluntary sterilization for Covered Persons or their spouses/Civil Union Partner;

7. Dental Services rendered by a dentist or Physician which are required as a result of accidental Injury to the jaw, teeth, mouth or face;

8. Special treatments, on an inpatient or outpatient basis, if rendered by a Physician or Hospital:
   a. X-ray and radiation therapy treatments;
   b. Chemotherapy;
   c. Shock therapy treatments;
   d. Renal dialysis treatments; or
   e. Allergy treatments, including allergy shots and allergy surveys.

D. Maternity Benefits

Expenses Incurred as a result of pregnancy will be eligible for benefits the same as any other Sickness under the Plan, except that the following provisions shall be applicable:

- a minimum of 48 hours of inpatient Hospital care for the mother and newborn child shall be provided following a vaginal delivery; and

- a minimum of 96 hours of inpatient Hospital care for the mother and newborn child shall be provided following a delivery by Caesarean section.

A shorter inpatient Hospital stay may be provided if a Physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn child meet the appropriate guidelines for a shorter stay, based upon an evaluation of the mother and newborn child and taking into consideration the availability of a post-discharge visit within 48 hours following the discharge, with either a Physician in his office or with an RN, or LPN supervised by an RN in the child's home.

In order to be eligible for benefits under this Section, a newborn child must meet the definition of Eligible Dependent as set forth herein, and must be properly enrolled in the Plan in accordance with the Section titled "Eligibility Date of Dependent's Coverage."

A mother and newborn child are considered separate persons for all purposes under the Plan, except that the following services are available for the child even if the mother is covered under the Plan and

there is no Dependent coverage in effect at the time of birth to provide benefits under the Plan for the child:

1. routine inpatient Hospital nursery charges and inpatient pediatric care;

2. routine inpatient examinations by a Physician other than the Physician who delivered the child or administered anesthesia during delivery; and

3. Expenses Incurred for circumcision.

E. Mental Illness/Substance Abuse

Notwithstanding any provision herein to the contrary, benefits are available for Medically Necessary treatment of Mental Illness or mental and nervous disorders, or for Substance Abuse (if such treatment is rendered in a Hospital or Substance Abuse Treatment Facility), rendered by a Physician, psychiatrist, registered clinical psychologist or Licensed Social Worker, and are subject to any limitations listed in the Schedule of Benefits.

F. Preventive Care (Also see "Addendum B – Preventive Care - Be Healthy Using Your Preventive Care Benefits" for a detailed list of covered Preventive Care services)

Well-child care (limited to Covered Dependents under age 18 years), and annual physicals, including immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved and other routine preventive evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task force are covered. The following items are also covered under this benefit:

1. Routine pap smears, including related services (limited to one per Calendar Year);

2. Routine prostate exam, including related services (limited to one per Calendar Year);

3. Adult physical examinations and immunizations, including all related charges;

4. Routine hearing examinations and hearing aids, their fittings or testing for the purpose of using a hearing aid;

5. Screening for the presence of occult breast cancer for women age 35 and older through the use of low-dose mammography (including digital mammography) as follows: one baseline mammogram for women age 35 to 39 and one mammogram each year for women age 40 and older. For women under age 40 with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors, screenings are covered at intervals considered Medically Necessary by the woman's health care Provider. A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue is covered when Medically Necessary as determined by a Physician. Services received from a Preferred Provider are not subject to any deductible or copayment/coinsurance provisions of the Plan.

6. A screening for colorectal cancer when ordered by your Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Outpatient Surgery/Procedures Copayments or Coinsurance will apply when procedures are performed in an Outpatient setting for which there is an associated facility fee (e.g., colonoscopy).

7. A complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer at least every three years for women at least 20 years of age but less than 40 years of age, and annually for women 40 years of age or older.

8. An annual screening for ovarian cancer using CA-125 serum tumor marker testing, transvaginal ultrasound or pelvic examination for females who are at risk of ovarian cancer.

9. Coverage is provided for inpatient hospitalization following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and evaluation of the patient; and for a post-discharge Physician office visit or in-home nurse visit within 48 hours after discharge.

10. Medically Necessary bone mass measurement and diagnosis and treatment of osteoporosis.

11. Shingles vaccine for Covered Persons age 60 or older.

12. Human papillomavirus vaccine (HPV).

G. Other Covered Services

1. Private-duty professional nursing services by a Registered Nurse or Licensed Practical Nurse, but only:

   a. on an inpatient basis, if the Employer determines that services provided are of such a nature or degree of complexity or quantity that they cannot be or are not usually provided by the regular nursing staff of the Hospital or other facility; or
   b. in the home, if the services provided are of such a nature that they cannot be provided by non-professional personnel;

2. Physical therapy (whether rendered by a Physician or licensed physical therapist); Medically Necessary Preventive Physical Therapy for the treatment of multiple sclerosis is covered when prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals;

3. Services of a qualified Physician or qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to Sickness or Injury or due to a congenital anomaly;

4. Services of a Physician or registered occupational therapist for constructive therapeutic activity designed and adapted to promote the restoration of useful physical function;

5. Phase I and Phase II cardiac rehabilitation services;

6. Local ground transportation provided by a professional ambulance service, to the nearest Hospital, between Hospitals or between a Hospital and a Skilled Nursing Facility, including air ambulance service, when Medically Necessary;

7. Processing and administration of blood or blood components, including the cost of the actual blood or blood components, unless replaced;

8. Chiropractic services performed by a chiropractor or Physician;

9. The following medical supplies:

    a. prosthetic appliances required to replace all or part of an organ or tissue or the function of an organ or tissue, including adjustment, repair or replacement of such devices where required due to wear or a change in the patient's condition, but specifically excluding dental appliances or vision appliances other than cataract lenses or standard glasses required promptly after, and because of, cataract surgery;

    b. durable medical equipment, including such things as internal cardiac valves, internal pacemakers, paraffin baths, bone screws, bolts, nails, plates, wheelchairs, hospital beds, iron lungs, artificial limbs and other similar devices (rental or purchase, at the option of the Plan);

    c. dressings, sutures, casts, splints, trusses, crutches, braces or other necessary medical supplies, with the exception of dental braces or corrective shoes;

    d. oxygen and rental equipment for its administration; and

    e. leg, back, arm and neck braces required due to Sickness or Injury.

10. Services obtained at a Birthing Center;

11. Treatment of temporomandibular joint (TMJ) syndrome and crainomandibular disorders;

12. Hospice care for terminally ill persons certified by a Physician as having a life expectancy of less than six months, limited as follows:

    a. Room and Board;
    b. Necessary Services and Supplies at a facility or in the home;
    c. Part-time nursing care;
    d. Consultation and case management services by a Physician;
    e. Physical therapy;
    f. Medical supplies and prescription drugs otherwise covered by the Plan; and
    g. Pre-bereavement and post-bereavement counseling during the 12 months following the death of the patient.

13. Home Health Care Expense Benefits, as follows:

    a. Benefits
    Reasonable and Customary Expenses Incurred for services and supplies furnished in the home of the Covered Person or Covered Dependent in accordance with a Home Health Care Plan, subject to the limitations set forth in the Schedule of Benefits and the following.

    Expenses covered under this Section include:

        i. part-time or intermittent nursing care by or under the supervision of a Registered Nurse;

        ii. part-time or intermittent home health aide services, when provided by a person specifically trained to provide such services, which consist primarily of caring for the patient;

        iii. physical therapy, occupational therapy, respiratory therapy and speech therapy provided by the Home Health Care Agency; and

iv. medical supplies, drugs and medications prescribed by a Physician, and laboratory services, to the extent such items would have been paid by the Plan if the Covered Person or Covered Dependent had remained in the Hospital or Skilled Nursing Facility.

b. Limitations
Each visit by a Home Health Care Agency team, other than a home health aide, shall be considered as one Home Health Care Visit, and four hours of home health aide service shall be considered as one Home Health Care Visit. Home Health Care Visits are limited as described in the Schedule of Benefits. No benefits are payable under this Section for:

i. services or supplies not covered by the Home Health Care Plan;

ii. services performed by an individual who ordinarily resides in the Covered Person's or Covered Dependent's home or is a member of the Covered Person's or Covered Dependent's Immediate Family;

iii. services of any social worker;

iv. Expenses Incurred for transportation; or

v. services or supplies rendered during any period in which the Covered Person or Covered Dependent is not under the continuing care of a Physician.

No Expenses Incurred for which benefits are payable in accordance with this Section shall be considered Expenses Incurred for the purpose of computing benefits payable under any other section of the Plan herein.

14. The following benefits for elective breast reconstruction in connection with a mastectomy:

a. reconstruction of the breast on which the mastectomy has been performed;

b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. prostheses and physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

15. Transplant Benefits: Reasonable and Customary Expenses Incurred for Medically Necessary human organ transplants, subject to the following:

a. Expenses Incurred for organ procurement from a non-living donor;

b. Expenses Incurred for organ procurement from a living donor;

c. Expenses Incurred for transportation, lodging and meals.

16. Prescription Drug Benefits: Reasonable and Customary Expenses Incurred for drugs which can be obtained only with the written prescription of a Physician, and insulin and disposable needles, subject to limitations set forth in the Schedule of Benefits pursuant to the drug card program separately maintained by the Association as part of this Plan. Copayment deductible expenses paid by a Covered Person or Covered Dependent in accordance with this Section shall not apply toward satisfaction of any other limitation herein.

17. Amino-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome when prescribed by a Physician as Medically Necessary;

18. Coverage for the diagnosis and Medically Necessary treatment of Autism Spectrum Disorders for Covered Persons or Covered Dependents under 21 years of age up to the annual benefit required by law.

    Treatment includes direct, consultative or diagnostic psychiatric care; direct or consultative psychological care; habilitative or rehabilitative care and therapeutic care. Services must be provided by a Physician, a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician. Coverage for Medically Necessary early intervention services must be delivered by a certified early intervention specialist.

    Services provided that are not directly related to the treatment of autism are not applied to the maximum benefit for Autism Spectrum Disorders.

19. Medically Necessary pain therapy related to the treatment of breast cancer is covered. "Pain therapy" means pain therapy that is medically based and includes reasonably defined goals, including but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals;

20. Medically Necessary habilitative services are covered for children under 19 years of age who have been diagnosed with a congenital, genetic or early-acquired disorder by a Physician licensed to practice medicine in all its branches.

    - Habilitative services include occupational therapy, physical therapy, speech therapy and other services prescribed by the treating Physician pursuant to a treatment plan to enhance the child's ability to function.

    - Congenital, genetic and early-acquired disorders include hereditary disorders, autism or an autism spectrum disorder, cerebral palsy or disorders resulting from illness or Injury which occurred prior to the child's developing functional life skills, such as walking, speaking or self-care skills.

    Treatment must be Medically Necessary and therapeutic. Treatment shall be administered by licensed Providers (speech-language pathologist, audiologist, occupational therapist, physical therapist, physician, nurse, optometrist, nutritionist, social worker or psychologist) under the direction of the treating Physician.

    Treatments that are experimental or investigational are not covered. Services that are solely educational in nature or reimbursed under state or federal law are not covered. Treatment of serious and non-serious Mental Illness or other mandated benefits are not included under this benefit.

21. Coverage is provided for inpatient hospitalization following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and evaluation of the patient; and for a post-discharge Physician office visit or in-home nurse visit within 48 hours after discharge.

22. Outpatient Self-Management Diabetic Training and Education, equipment, supplies and foot care, when Medically Necessary and provided by a Physician or duly certified, registered or

licensed health care professional with expertise in diabetes management, for treatment of Type I diabetes, Type II diabetes and gestational diabetes mellitus as follows:

a. covered medical supplies:

i. blood glucose monitors;
ii. blood glucose monitors for the legally blind;
iii. cartridges for the legally blind; and
iv. lancets and lancet devices.

b. covered pharmaceuticals and supplies:

i. insulin;
ii. syringes and needles;
iii. test strips for glucose monitors;
iv. FDA-approved oral agents used to control blood sugar; and
v. glucagon emergency kits.

Notwithstanding the foregoing, any item listed herein that is an eligible expense under any separate prescription drug card benefit maintained by the Employer shall not be considered an eligible expense under this Plan.

c. regular foot care exams.

Benefits for Out-Patient Self-Management Training and Education are limited as follows:

a. three visits to a Physician or certified, registered, or licensed health care professional with expertise in diabetes management during the first year following the initial diagnosis of diabetes; and

b. two visits to a certified, registered, or licensed health care professional within one year following a significant change in the patient's symptoms or condition. A "significant change" in the patient's condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen;

c. two visits for nutritional counseling per Calendar Year.

Dental Benefits

A. Covered Services

Reasonable and Customary Expenses Incurred for:

1. Preventive Dental Services

a. cleanings and scaling of teeth;

b. fluoride application to a child's teeth;

c. space maintainers and their fitting;

d. dental sealants;

e. Diagnostic and Therapeutic Services

i. diagnostic services to determine necessary care, for

1. charges for full mouth X-rays;

2. charges for bite-wing X-rays; and

3. charges for a diagnostic oral examination.

2. Basic Dental Services

a. extraction of one or more teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw, but not including additional charges for removal of stitches or post-operative examination;

b. treatment of the gums and supporting structure of the teeth;

c. root canals and other endodontic treatment;

d. general anesthetics and their administration in connection with Oral Surgery, periodontics, fractures or dislocations;

e. injectable antibiotics administered by a dentist or Physician;

f. fillings.

3. Major Dental Services

a. full or partial dentures, fixed bridges, or adding teeth to an existing denture, if required because of loss of natural teeth while the person is covered for this benefit, and to replace such teeth or to replace an existing prosthesis which is over five years old and cannot be made serviceable;

b. repair and rebasing of existing dentures which have not been replaced by a new denture.

c. Restorative Services and Supplies: fillings and crowns necessary to restore the structure of teeth broken down by decay or Injury, but,

i. the charge for a crown or gold filling will be limited to the charge for a silver, porcelain or other filling unless the tooth cannot be restored with such other material; and

ii. the charge for replacement of a crown or gold filling is covered only if the crown or filling is over five years old.

Specialized techniques involving precision attachments, personalization or characterization and additional charges for adjustments within six months from installation are not included as covered dental charges. Benefits for both a temporary and permanent prosthesis will be limited to the charge for the permanent one.

4. Orthodontic Dental Services

Services of a dentist and supplies in connection with orthodontic treatment, other than for extractions and space maintainers, to correct malposed teeth, provided:

a. the dentist has diagnosed one of the following conditions:

i. the existence of extreme bucco-lingual version of teeth, either unilateral or bilateral;

ii. a protrusion of the maxillary teeth of more than four millimeters;

iii. a protrusive or retrusive relation of the maxillary or mandibular arch of at least one cusp; or

iv. an arch length discrepancy of four or more millimeters; and

b. the first active appliance was inserted while the child was covered for this benefit.

Benefits are not available for any charge in excess of the charge customarily made:

i. for similar services and supplies by dentists in the locality concerned; or

ii. in a case where alternate service or supplies are customarily available for such care and treatment for the least expensive service or supply resulting in professionally adequate treatment.

Benefits for the entire course of treatment which are in excess of the deductible will be divided into equal 90-day portions, the first portion being deemed incurred as of the date an active appliance is first inserted. The last portion will be deemed incurred 90 days before the earlier of:

i. the date the course of treatment is estimated to be complete; or

ii. two years from the date the first such portion is deemed incurred. No portion will be deemed to be incurred on any date unless the child is insured for this benefit on that date.

B. Limitations

1. Deductible Expenses

During each Calendar Year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for a portion of covered Expenses Incurred ("Deductible Expenses") as set forth in the Schedule of Benefits. This limitation does not apply to Expenses Incurred for Preventive Dental Services as defined herein.

The Deductible Expenses limitation shall be paid only once during a Calendar Year by each Covered Person or Covered Dependent, and shall be paid only once if (i) a Covered Person and one or more of his or her Covered Dependents, or (ii) two or more Covered Dependents of a Covered Person incur Injuries in the same accident.

Notwithstanding any provision in this Dental Benefits Section to the contrary, the total number of Deductible Expense limits to be paid by a Covered Person and his Covered Dependents during one Calendar Year under the provisions of this Section shall not exceed the limitation set forth in the Schedule of Benefits.

The Deductible Expenses incurred under this Section of the Plan shall not be applied to satisfy the Deductible Expense requirement under any other Section of the Plan.

2. Shared Expenses

Notwithstanding any provision herein to the contrary, during each Calendar Year, a Covered Person or Covered Dependent shall be responsible for a portion of Reasonable and Customary Expenses Incurred pursuant to this Dental Benefits Section, in excess of the expenses excluded pursuant to

subsection (1) above, determined in accordance with the limitations set forth in the Schedule of Benefits.

3. Maximum Dental Benefits

   Notwithstanding any provision herein to the contrary, the maximum benefits available for each Covered Person or Covered Dependent pursuant to this Section shall not exceed the limitation set forth in the Summary of Benefits.

4. Alternate Benefits

   If more than one course of treatment is available, benefits will be computed and paid based on the least costly course of treatment.

5. Care By More Than One Dentist

   If a Covered Person or Covered Dependent switches dentists during a particular course of treatment, benefits will be provided as if the course of treatment had been provided under the original treatment plan.

6. Limitations

   The following limitations apply to benefits provided pursuant to this Dental Benefits Section, in addition to those limitations specified in the General Limitations Section herein which are applicable to all benefits provided under the Plan. Pursuant to these additional limitations, no benefits will be provided under this Dental Benefits Section for:

   a. dental services not ordered by a Physician;

   b. dental services which do not meet the standards set by the American Dental Association;

   c. dental services incurred due to loss or theft of dentures or bridges;

   d. dental services obtained from a health department maintained by the Employer, a union, a trustee or a similar type of entity;

   e. dental services obtained for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance;

   f. the following items:

      i. myofunctional therapy;

      ii. athletic mouthguards;

      iii. implants;

      iv. oral hygiene, dietary, plaque control and other educational programs;

      v. duplicate prosthetic appliances;

      vi. porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charges that would have been a Covered Dental Charge for acrylic veneered crowns or onlays; and

      vii. gold inlays or onlays.

g. dental services for an Injury or Sickness due to employment with an employer or self employment where workers' compensation benefits are available;

h. dental services for orthodontic diagnosis, evaluation, precare or treatment; or

i. dental services for treatment of temporomandibular joint syndrome.

Vision Benefits

A. Covered Services

Benefits for Reasonable and Customary Expenses Incurred for the following:

1. Eye Exam

2. Lenses, per pair, for:

   a. Single vision;

   b. Bi-focal;

   c. Tri-focal;

   d. Lenticular.

3. Frames

4. Contact lenses, per pair:

   a. the amount specified in the Schedule of Benefits, if prescribed for a Covered Person or Covered Dependent:

      i. where visual acuity is not correctable to 20/70 in the better eye except by the use of contact lenses;

      ii. as a requirement following cataract surgery; or

      iii. when the patient is being treated for a condition such as keratoconus or anisometropia, and contact lenses are customarily prescribed as part of the treatment.

   b. the amount specified in the Schedule of Benefits, if otherwise prescribed.

B. Limitations

1. The maximum amount for a single lens is 50 percent of the maximum amount for a pair of lenses.

2. If the scheduled amount of benefits is greater than the actual Expenses Incurred, the excess will be added to the scheduled amount for benefits for Expenses Incurred within 60 days of the date the initial expense was incurred.

3. For each Covered Person or Covered Dependent, during any 24-month period, benefits are not payable for more than the benefits stated in the Vision Benefits Summary of Benefits.

4. Benefits are not payable for Expenses Incurred:

    a. in connection with orthoptics, vision training or subnormal vision aids;

    b. for lenses obtainable without a prescription;

    c. for any service or supply not listed in the schedule of benefits.

CLAIM PROVISIONS

Information Statement

An information statement must be completed periodically by the Covered Person and properly signed as required by the Employer. The procedures outlined below must be followed by Covered Persons and Covered Dependents ("Claimants") to obtain payment of benefits under the Plan.

Benefit Claims

A. Discretion of Plan Administrator

All claims must be filed with the Contract Administrator or other appropriate entity as directed by the Plan Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with applicable law. This means that claims will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them. The responsibility to process claims in accordance with the Plan is delegated to the Contract Administrator (or other appropriate entity as directed by the Plan Administrator) provided, however, that the Contract Administrator (or other appropriate entity) is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Claimant has not incurred a covered expense; that the benefit is not covered under the Plan; or if the Claimant shall fail to furnish such proof as is requested; or if coverage is rescinded due to fraud or a misrepresentation of a material fact, no benefits shall be payable under the Plan.

B. When Claims must be Filed

Claims must be filed within 90 days of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

A Pre-Service Claim is considered to be filed when the request for approval of treatment or services is made and received in accordance with the Plan's procedures. A Post-Service Claim is considered to be filed when the following information is received in accordance with the Plan's procedures, together with a Form HCFA or Form UB92 or other approved standardized method:

1. the date of service;
2. the name, address, telephone number and tax identification number of the provider of the services or supplies;
3. the place where the services were rendered;
4. the diagnosis and procedure codes;
5. the amount of charges;
6. the name of the Covered Person; and
7. the name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received in accordance with the Plan's procedures within 45 days from receipt by the Claimant of the request for additional information. **Failure to provide the requested information may result in claims being denied or reduced.**

C. Timing of Claim Decisions

The Plan shall notify the Claimant of the benefit determination within the following time frames:

1. Pre-Service Claims

   a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim (unless an extension has been requested, then prior to the end of the 15-day extension period).

   b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than five days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the Claimant (if additional information was requested during the extension period).

2. Urgent Care Claims

   a. If the Claimant has provided all of the information needed to process the claim, as soon as possible, but not later than 72 hours, unless an extension has been requested, then within 48 hours of the end of the extension period. If the notification is provided orally, a written or electronic notification will be provided to the Claimant within three days after the oral notification.

   b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed within 24 hours of receipt of the claim. The Claimant will be provided a reasonable amount of time, but not less than 48 hours, to provide the specified information. If the requested information is not received within the time frame given to provide the information, the claim will be denied. The Claimant will be notified of a determination of benefits within 48 hours after receipt of the requested information. If the notification is provided orally, a written or electronic notification will be provided to the Claimant within three days after the oral notification.

3. Concurrent Claims

   Any reduction or termination of benefits for concurrent care (other than by Plan Amendment or termination) before the end of an approved period of time or number of treatments is considered a claim denial. The Claimant will be notified in advance of the reduction or termination to allow the Claimant opportunity to appeal the decision before the benefit is reduced or terminated.

   a. Claims for concurrent care will be decided within 24 hours of the receipt of the claim, provided such request is made at least 24 hours before the expiration of the prescribed period of time or number of treatments.

b. Claims for concurrent care which are not received at least 24 hours before the expiration of the prescribed period of time or number of treatments will be decided in accordance with the Urgent Care Claims procedures discussed above.

4. Rescission of Coverage

A Rescission of coverage for fraud or misrepresentation of a material fact will constitute a claim denial. The Plan will provide the Claimant at least 30-days' advance written notice of such action to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination.

5. Post-Service Claims

a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

b. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan and the Claimant.

6. Extensions – Pre-Service Claims

The benefit determination period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

7. Extensions – Post-Service Claims

The benefit determination period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

8. Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a Claim is deemed to be filed in accordance with the procedures of the Plan.

D. Notification of an Adverse Benefit Determination

The Plan shall provide a Claimant with a notice, either in writing or electronically. The notice will be stated in a manner calculated to be understood by the Claimant. The notice will contain the following information:

1. (Effective 7/1/2011) information sufficient to allow the Claimant to identify the claim involved (including date of service; the health care provider; the claim amount, if applicable;

2. (Effective 7/1/2012) a statement that the diagnosis code and its corresponding meaning; and the treatment code and its corresponding meaning will be provided free of charge upon request;

3. a reference to the specific portion(s) of the Plan upon which a denial is based;

4. specific reason(s) for a denial;

5. a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;

6. a description of the Plan's internal and external review procedures and the time limits applicable to the procedures, (this will include a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review);

7. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

8. the statement "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.";

9. any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);

10. in the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or an experimental treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request; and

11. (Effective 7/1/2011) information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeal and external review process.

Appeal of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, or if coverage is rescinded for fraud or misrepresentation of a material fact, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

A. that Claimants have at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination; requests for review of a denial due to the Rescission of coverage must be made within 30 days after receiving the notification of the Adverse Benefit Determination;

B. that Claimants have the opportunity to submit written comments, documents, records, testimony and other information relating to the claim for benefits;

C. for a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

D. for a full and fair review that takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

E. that, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified;

F. for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

G. that a Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits in the possession of the Plan; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

The Plan Administrator shall provide the Claimant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the Claimant to respond.

First Appeal Level

A. Requirements for First Appeal

The Claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination (30 days following receipt of the notice of an adverse benefit determination for rescission of coverage). To file an appeal in writing, the Claimant's appeal must be addressed as follows and mailed to: Appeals, P. O. Box 284, Peoria, IL 61650-0284.

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. the name of the Employee/Claimant;

2. the Employee/Claimant's Social Security number;

3. the group name or identification number;

4. all facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in them being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal;

5. a statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

B. Timing of Notification of Benefit Determination on First Appeal

The Plan or Contract Administrator provide the Claimant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the Claimant to respond.

The Plan shall notify the Claimant of the Plan's benefit determination on review within the following time frames:

1. for Urgent Care Claims: no later than 72 hours after receipt of the request. If there is an Adverse Benefit Determination on a claim involving Urgent Care where the time for completion of a standard appeal would seriously jeopardize the Claimant's life or the Claimant's ability to regain maximum function, the Claimant may request an expedited appeal. The request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile or other similarly expeditious method. Alternatively, the Claimant may also request an expedited external review.

2. for Pre-Service Claims: within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

3. for Post-Service Claims: within a reasonable period of time, but not later than 30 days after receipt of the appeal.

4. for Concurrent Care Claims: in accordance with the Urgent Care Claims, Pre-Service Claims or Post-Service Claims procedures discussed above.

5. for Rescission of coverage: no later than 15 days after the receipt of the request, provided the appeal was received within 30 days of the initial claim denial.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

C. Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan shall provide a Claimant with notification, in writing or electronically, of the Plan's adverse benefit determination on review, except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification. The notice will be stated in a manner calculated to be understood by the Claimant. The notice will contain the following information:

1. (Effective 7/1/2011) information sufficient to allow the Claimant to identify the claim involved (including date of service; the health care provider; the claim amount, if applicable;

2. (Effective 7/1/2012) a statement that the diagnosis code and its corresponding meaning; and the treatment code and its corresponding meaning will be provided free of charge upon request;

3. the specific reason or reasons for the denial, including the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim;

4. reference to the specific portion(s) of the Plan on which the denial is based;

5. the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);

6. any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);

7. if the adverse benefit determination is based upon a medical judgment, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

8. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

9. a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

10. a description of the Plan's internal and external review procedures and the time limits applicable to the procedures;

11. a statement of the Claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review;

12. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency." and

13. (Effective 7/1/2011) information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

D. Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan shall provide such access to, and copies of, documents, records and other information described in subsections (3) through (5) of section (C) relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

A. Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Claimant has 60 days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

B. Timing of Notification of Benefit Determination on Second Appeal

The Plan shall provide the Claimant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge as soon as

possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the Claimant to respond.

The Plan shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. for Pre-Service Claims: within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

2. for Post-Service Claims: within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

3. for Urgent Care Claims: within the initial 72-hour period allowed for a first-level appeal. If the time for completion of second appeal would seriously jeopardize the Claimant's life or the Claimant's ability to regain maximum function, the Claimant may request an expedited appeal. The request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile or other similarly expeditious method. Alternatively, the Claimant may also request an expedited external review.

4. for Concurrent Claims: in accordance with the Urgent Care, Pre-Service Claims or Post-Service Claims listed above.

5. for Rescission of Coverage: within 15 days after receipt of the request, provided request is made within 30 days of the date of the initial notice of claim denial.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

C. Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is needed, and (ii) a description of the Plan's internal review procedures and the time limits applicable to the procedures. See the section titled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

D. Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan shall provide such access to, and copies of, documents, records and other information described in subsections (3) through (5) of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

E. Decision on Second Appeal to be Final

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

External Review

If a Claimant receives a Final Adverse Benefit Determination under the Plan's internal claims and appeals procedures, or if the Plan does not follow the appeal procedures properly (except for failures that are based on de minimis violations that do not cause and are not likely to cause, prejudice or harm to the Claimant), he or

she may request that the claim be reviewed under the Plan's external review process. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

A. The Plan waives any right to claim that the Claimant failed to exhaust administrative remedies because the Claimant did not submit a request for an external review.

B. Any statute of limitation or other defense based on timeliness is pended during the time of the external review.

C. The Claimant may submit a request for an external review only after exhausting the other levels of appeal discussed above.

D. Upon request, the Plan will provide the Claimant the information necessary to make an informed judgment about requesting an external review.

E. The Claimant will not be responsible for paying any fees associated with an external review.

F. If an appeal is denied, the Plan Administrator's written response to the Claimant will cite the specific Plan provision(s) upon which the denial is based.

The Plan Administrator or Contract Administrator will determine whether the claim is eligible for review under the External Review process. This determination is based on whether:

1. the Claimant is or was covered under the Plan at the time the claim was made or incurred;

2. the denial relates to the Claimant's failure to meet the Plan's eligibility requirements;

3. the Claimant has exhausted the Plan's internal claims and appeal procedures (a Claimant may request an expedited external review under certain circumstances [see the section "Expedited External Review"]); and

4. the Claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan will provide written notification to the Claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, Plan will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll-free number (1-866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The Claimant will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan Administrator or Contract Administrator will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan Administrator. The Plan Administrator may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the external review process will end.

If the Plan Administrator does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

1. the Claimant's medical records;

2. the attending health care professional's recommendation;

3. reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant or the Claimant's treating provider;

4. the terms of the Plan;

5. appropriate practice guidelines;

6. any applicable clinical review criteria developed and used by the plan; and

7. the opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

1. a general description of the reason for the external review, including information sufficient to identify the claim;

2. the date the IRO received the assignment to conduct the review and the date of the IRO's decision;

3. references to the evidence or documentation the IRO considered in reaching its decision;

4. a discussion of the principal reason(s) for the IRO's decision;

5. a statement that the determination is binding and that judicial review may be available to the Claimant; and

6. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Expedited External Review
Generally, a Claimant must exhaust the Plan's claims and appeal procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if:

A. the Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

B. the Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO

receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Plan.

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. In the event the Plan fails to properly follow its internal claims appeal procedures (except for failures that are based on de minimis violations that do not cause and are not likely to cause, prejudice or harm to the Claimant), the claims appeal procedures will be deemed exhausted. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A Claimant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

Facility of Payment

If a Covered Person or Covered Dependent dies while benefits provided for Hospital, nursing, medical or surgical services remain unpaid, the Plan may, at its option, make direct payments to the individual or institution on whose charges the claim is based or to the surviving spouse/Civil Union Partner of the Covered Person, or if none, to his or her surviving child or children (including legally adopted child or children and stepchild or child) share and share alike, or, if none, to the executors or administrators of the Covered Person's or Covered Dependent's estate.

Minor or Incompetency

If a Covered Person or Covered Dependent is a minor or, in the opinion of the Plan, not competent to give a valid receipt for payment of any benefit due him or her under the Plan, and if no request for payment has been received by the Plan from a duly appointed guardian or other legally appointed representative of that person, the Plan may, at its option, make direct payment to the individual or institution appearing to the Plan to have assumed the custody or the principal support of that person.

Discharge

Any payment by the Plan in accordance with these provisions will discharge the Employer and the Contract Administrator from all further liability to the extent of the payment made.

Time Limitations

If any time limitations provided in the Plan for giving notice of claims, furnishing proof of loss or for bringing any action at law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

Claims Mistakenly Paid

The Plan shall have the right to recover any payment of claims which have been mistakenly paid on behalf of a Claimant. This includes the right to recover benefits paid on the basis of claims filed which were fraudulently or intentionally misstated by the Claimant. The Claimant will be notified in writing and given an opportunity for review in accordance with the claims procedures herein. A payment by the Plan is not an admission by the Plan, the Employer or the Contract Administrator that the Expenses Incurred with respect to which a claim for benefits is filed is eligible for benefits under this Plan.

ADMINISTRATION

Assignment

Benefits under this Plan may be assigned to a provider upon written authorization of the Covered Person or Covered Dependent.

Withholding of Benefit Payments

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Contract Administrator to withhold such payments until there shall have been made an adjudication of such question or dispute which in the Employer's sole judgment is satisfactory to it, or until the Employer and Contract Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

Medical Examination

The Plan shall have the right, through a Physician of its choice, to examine a Covered Person or Covered Dependent as often as may be reasonable during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

The Plan shall be entitled to receive any and all reports regarding such examinations or autopsies.

Right to Receive and Release Information

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

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the Protected Health Information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

The employees or classes of employees that will be permitted access to Protected Health Information as set forth in this paragraph are: Consultant, Bank Officers.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

A. not use or further disclose the information other than as permitted or required by the Plan or as required by law;

B. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan ("Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.);

C. ensure that any agents (including subcontractors) to whom it provides Protected Health Information received from the Plan agree to in writing the same restrictions and conditions that apply to the Plan Sponsor (including the implementation of reasonable and appropriate security measures to protect Electronic Protected Health Information) with respect to such information;

D. not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

E. report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

F. make available Protected Health Information in accordance with 45 C.F.R. 164.524;

G make health information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. 164.526;

H. make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

I. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.;

J. if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

K. ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of Protected Health Information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

Facility of Reimbursement

If payments which should have been made under this Plan have been made under any other plan or plans, the Plan may, at its sole discretion, pay to any organization making such other payments any amounts which it determines will satisfy the intent of the Plan. Amounts so paid shall be deemed benefits paid under this Plan and, to the extent of such payments, the Employer and Contract Administrator shall be fully discharged from liability under this Plan.

Right to Recovery

If the total payments made by the Plan as to any expenses at any time are more than the maximum payment then necessary to satisfy the intent of the Plan, the Plan shall have the right to recover the extra amount of such payments from one or more of the following, as the Plan will determine: any person to, for or with respect to whom such payments were made, any other insurance companies, and any other organizations.

Subrogation and Reimbursement

A. Payment Conditions

1. The Plan, in its sole discretion, may elect, but is not required, to conditionally advance payment or extended credit of medical benefits in those situations where a Sickness, Injury or disability is caused in whole or in part by, or results from, the acts or omissions of a third party or from the acts or omissions of a Covered Person or Covered Dependent (including such Covered Person or Covered Dependent's beneficiaries, heirs or assigns) where any other insurance is available, including, but not limited to, no-fault, uninsured motorist, underinsured motorist, medical payment provisions or other insurance policies or funds ("Coverage").

2. The Covered Person or Covered Dependent, his or her attorney, and/or the legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of this provision in its entirety and agrees to maintain 100 percent of the Plan's payment of benefits or the full extent of payment from any one or a combination of first- and third-party sources in trust and without dissipation except for reimbursement to the Plan or its assignee. By accepting benefits under the Plan, the Covered Person or Covered Dependent agrees that the Plan shall have an equitable lien on any funds received by the Covered Person or Covered Dependent or such person's attorney, if any, from any source and shall be held in trust until such time as the obligation under this provision is fully satisfied.

3. In the event a Covered Person or Covered Dependent settles, recovers or is reimbursed by any third party or Coverage, the Covered Person or Covered Dependent agrees to reimburse the Plan for all benefits paid or that will be paid as a result of said Sickness, Injury or disability. If the Covered Person or Covered Dependent fails to reimburse the Plan out of any judgment or settlement received, the Covered Person or Covered Dependent will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money.

B. Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person or Covered Dependent agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person or Covered Dependent is entitled, regardless of how they are classified or characterized.

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

3. The Plan may, in its own name or in the name of the Covered Person or Covered Dependent or the Covered Person or Covered Dependent's personal representative, commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

4. If the Covered Person or Covered Dependent fails to make a claim against or pursue damages against:

   a. the responsible party, its insurer or any other source on behalf of that party;

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

c. any policy or contract of insurance from any insurance company or guarantor of a third party;

d. workers' compensation or other liability insurance company; or

e. any other source, including, but not limited to, crime victim restitution funds; any medical, disability or other benefit payments; and no-fault or school insurance coverages;

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

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100 percent of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, and without regard to whether the Covered Person or Covered Dependent is fully compensated by his or her recovery from all sources. The obligation exists whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. The obligation exists regardless of how it is classified or characterized. If the Covered Person's or Covered Dependent's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. The Plan's equitable subrogation lien specifically supersedes all common law or statutory rules and doctrines such as the "make whole doctrine," the "common fund doctrine" and the law of any state prohibiting any assignment of rights, which interfered with, or compromises in any way, the Plan's equitable subrogation lien.

3. The Plan will not pay or be responsible for any expenses, attorney's fees, costs or other monies incurred by the attorney for the Covered Person or Covered Dependent or his or her beneficiaries, commonly known as the common fund doctrine. No court costs, expert's fees, attorney's fees, filing fees or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without the prior written consent of the Plan.

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

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

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

D. Excess Insurance

If, at the time of Sickness, Injury or disability, there is available, or potentially available (based on information known or provided to the Plan, to the Covered Person or Covered Dependent) any other

Coverage (including, but not limited to, Coverage resulting from a judgment at law, or settlements) the benefits under this Plan shall apply only as excess insurance over such other sources of Coverage. The Plan's benefits shall be excess to:

1. the responsible party, its insurer or any other source on behalf of that party;

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

3. any policy of insurance from any insurance company or guarantor of a third party;

4. workers' compensation or other liability insurance company; or

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

E. Wrongful Death Claims

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

F. Obligations

It is the Covered Person's or Covered Dependent's obligation to:

1. cooperate with the Plan or any representatives of the Plan, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in a trial to preserve the Plan's subrogation rights;

2. provide the Plan with pertinent information regarding the Sickness, Injury or disability, including accident reports, settlement information and any other requested additional information;

3. take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

4. do nothing to prejudice the Plan's rights of subrogation and reimbursement;

5. promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

6. not settle, without the prior consent of the Plan, any claim that the Covered Person or Covered Dependent may have against any legally responsible party or Coverage to the extent the Plan is or may be entitled to any part of such settlement proceeds.

Failure to comply with any of these requirements by the Covered Person or Covered Dependent, his or her attorney or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds or payments due under this Plan may be withheld until the Covered Person or Covered Dependent satisfies his or her obligation. If the Covered Person or Covered Dependent fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Sickness, Injury or disability, out of any proceeds, judgment or settlement received, the Covered Person or Covered Dependent will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person or Covered Dependent.

G. Minor Status

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

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

H. Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation/reimbursement rights.

I. Severability

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

Coordination of Benefits

In addition to benefits payable under this Plan, a Covered Person or Covered Dependent may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those which provide benefits or services for, or by reason of, medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not, by any government or tax-supported program (including Medicare) or any similar plan or program.

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan and under all plans covering an individual exceed the total Expenses Incurred.

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the total allowable Expenses Incurred. No plan will pay more than it would have paid without this special provision.

The following rules apply to determine which plan is Primary and which plan is Secondary:

A. If one plan has no coordination of benefits provision, it is automatically Primary.

B. A plan will be Primary if it covers the individual as an employee and Secondary if it covers the individual as a dependent.

C. If an individual is covered as a dependent under two or more plans, the plan which covers the individual as a dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the same date of birth, the plan covering the individual for the longer period of time is Primary.

D. In the case of children of divorced parents, in the absence of court-determined responsibility, the plan covering the parent with custody is Primary. If the parent without custody has court-determined

responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is Primary.

E. A plan will be Primary if it covers the individual as an employee and Secondary if it covers the individual as (i) a former employee, (ii) a retiree, or (iii) an individual who has elected to continue benefits under the Plan pursuant to the Continuation of Benefits Sections herein.

F. If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Notwithstanding any provision herein to the contrary, if a Covered Person or Covered Dependent is eligible for Medicare, benefits otherwise payable on behalf of that Covered Person or Covered Dependent shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

Information necessary to the administration of this Section will be required at the time a claim is submitted.

Coordination with Medicare, Medicaid and SCHIP

A. Medicare

This Plan will be considered the Primary Plan for Covered Persons who are current Employees and their Covered Dependents who are nevertheless eligible for Medicare benefits if (i) such Covered Persons or Covered Dependents are age 65 years or older and their Employer employs 20 or more Employees, or (ii) such Covered Persons or Covered Dependents are disabled and any Employer under this Plan employs 100 or more Employees. Except to the extent required by law for end stage renal disease, Medicare shall be considered the Primary Plan for all other Covered Persons who become eligible for Medicare and their Covered Dependents, unless the Covered Person on behalf of himself or herself and his/her Covered Dependents rejects coverage under this Plan. In the event of an election to terminate coverage, benefits will no longer be available under this Plan as either a Primary Plan or a Secondary Plan.

B. Medicaid and SCHIP

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such Covered Person or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) or a State Child Health Insurance Program (SCHIP) approved under Title XXI of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for, or is provided medical assistance under, a State plan for medical assistance approved under Title XIX or a State Child Health Insurance Program approved under Title XXI of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX or a State Child Health Insurance Program approved under Title XXI of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

Case Management

In the case where the patient's condition is expected to be, or is of, a serious nature, the Plan, pursuant to the reasonable exercise of its discretion, may arrange for review and/or case management services from a professional qualified to perform such services. Upon the advice of such professional, the Plan shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result can be achieved without a sacrifice to quality of patient care.

Qualified Medical Child Support Order

The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

A. An order which purports to be a QMCSO must be served on the Employer or its designee.

B. The Employer or its designee shall, within a reasonable amount of time of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

   1. a clause which creates or recognizes the existence of a Dependent's right to receive benefits under the Plan;

   2. the name and last known mailing address of the Covered Person with respect to whom the order is issued and each Dependent covered by the order;

   3. a reasonable description of the type of coverage to be provided by the Plan to each Dependent;

   4. the time period to which the order applies; and

   5. the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

C. If, within a reasonable amount of time of the date of the order, it is in the judgment of the Employer or its designee that the order does not meet the requirements of a QMCSO, it shall be returned to the legal counsel/issuing agency who prepared the order for revision. The Employer or its designee shall notify all parties involved (including a designated representative of the Covered Dependent) of the specific reasons for the determination. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

D. When the Employer or its designee makes a preliminary determination that an order satisfies the requirements of a QMCSO, it shall forward the order to the Plan Administrator for review. The Employer or its designee shall make the final determination of the status of the order.

E. The Employer or its designee shall, within a reasonable amount of time of its receipt of the order, notify all parties involved (including a designated representative of the Covered Dependent) of the Employer's decision and of the respective parties' entitlement to benefits and furnish the Covered Dependent's designated representative a description of the coverage available and the effective date of the coverage, including, if not already provided, a copy of the summary plan description and any forms, documents, or information necessary to effectuate such coverage.

F. If it is determined that the order is not a Qualified Order, each named child may have the right to appeal that decision, as permitted or required by applicable law, by submitting a written letter of appeal to the Plan Administrator.

Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the Covered Dependent or the Covered Dependent's custodial parent.

Termination of Coverage

When coverage under this Plan stops, Covered Persons and/or Covered Dependents will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or IMRF Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the covered Employee and/or covered IMRF Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or IMRF Employee's and/or Dependent's paid contributions.

A Termination of Covered Person Coverage

The coverage of any Covered Person with respect to himself or herself shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

1. the date the Plan is terminated, or – with respect to a specific benefit – the date the specific benefit is terminated;

2. the date the Covered Person ceases to be in a class of employees eligible for coverage;

3. the date beginning the period for which the Covered Person has failed to make any required contribution for coverage;

4. the date on which the Covered Person's employment with the Employer terminates; or

5. the date of the Covered Person's death.

B. Termination of Covered Dependent Coverage

The coverage of any Covered Dependent shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

1. the date coverage terminates for the Employee upon whom the Covered Dependents depends for eligibility;

2. unless otherwise noted, the date such Dependent ceases to be an Eligible Dependent as defined herein;

3. the date the Plan is modified to terminate Dependent coverage;

4. the date beginning the period for which the Covered Person or Covered Dependent has failed to make any required contribution for Dependent coverage, if contributions are required;

5. the date the spouse/Civil Union Partner and/or qualified dependent child becomes eligible for coverage under the Plan as an Employee;

6. the date the Plan is terminated or – with respect to a specific benefit – the date the specific benefit is terminated; or

7. the date of the Covered Dependent's death.

Extension of Benefits

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, without regard to the continuation of benefits provisions of the Plan, benefits under the Plan may nevertheless be extended under the specific circumstances enumerated herein. Unless otherwise noted, any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section.

A. Disabled Child

The maximum age for a Dependent child, as specified in this Plan shall not serve to terminate or preclude coverage for any child who is incapable of self-sustaining employment by reason of mental or physical disability provided:

1. such child is dependent upon the Employee for at least 50 percent of his or her support and maintenance;

2. such child was a Covered Dependent and was suffering from such mental or physical disability on the date his or her status as a Covered Dependent would otherwise terminate; and

3. proof of such incapacity is furnished to the Employer at such times as the Employer may reasonably require of the Covered Person on the child's behalf.

B. Total Disability

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent who is suffering from a Total Disability, benefits will continue to be provided for the Covered Person (and his or her Covered Dependents) or the Covered Dependent ,while the person continues to suffer from Total Disability, until the earlier of (i) the date the Covered Person or Covered Dependent fails to make any contribution required for coverage, if contributions are required, or (iii) three months following the beginning of the Total Disability.

C. State Mandate, Collective Bargaining Agreement or Employer Personnel Policy

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, benefits will continue to be provided for those individuals to the extent required by law, a collective bargaining agreement in effect with respect to the Employer or the Employer's personnel policies.

General Limitations

In addition to any limitations or exclusions stated elsewhere in the Plan, no benefits are payable under this Plan for Expenses Incurred:

A. for charges which exceed the Reasonable and Customary charge for the service rendered (except to the extent that a Preferred Provider agreement or similar agreement prohibits the application of this limitation) or charges for which payment by the Covered Person or Covered Dependent is not legally required;

B. for treatment paid for by any agency of the United States Government or any state or political subdivision, or provided by or in a Hospital operated by any agency of the United States Government or any state or political subdivision, unless the Covered Person or Covered Dependent is legally required to pay such charges;

C. for or in connection with:

1. Sickness or Injury for which the Covered Person or Covered Dependent is entitled to benefits under any workers' compensation law, employers' liability law or similar laws;

2. Hospital, surgical and medical services or supplies unless such expense is incurred upon the recommendation of a Physician for diagnosis or treatment of an Injury or Sickness;

3. Injury or Sickness arising out of war (declared or undeclared) or service in any military forces or civilian non-combatant unit serving with such forces;

4. Injury or Sickness sustained (i) during the voluntary participation in a riot or the commission of an illegal act or crime, or (ii) while under the influence of alcohol or other drug or controlled substance which is not prescribed by a Physician. For purposes of this section, a person shall be presumed to be under the influence of alcohol if his or her blood alcohol level equals or exceeds the limit for driving under the influence of alcohol as determined by the law of the state in which the Injury occurred. In addition, a person may be considered to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the Plan Administrator. Expenses for the treatment of Substance Abuse as specified in this Plan are covered. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

   The limitations of this section shall not apply unless there is a direct causal relationship between the activity described in (i) or (ii) and the Sickness or Injuries sustained;

5. services or supplies which constitute personal comfort or beautification items, television or telephone use, education or training, or expenses actually incurred by persons who are not Covered Persons or Covered Dependents;

6. cosmetic surgery, except for treatment necessitated by accidental Injury or for correction of a congenital malformation of a Dependent child;

7. except as specified elsewhere, health examinations of a routine periodic nature, or Expenses Incurred for immunizations not necessary for the treatment of a Sickness or Injury;

8. suicide, attempted suicide or intentionally self-inflicted Injury or Sickness (to the extent permitted by law);

9. services performed by any person who is a member of the Covered Person's or Covered Dependent's Immediate Family, or who normally resides in the Covered Person's or Covered Dependent's home;

10. services, supplies or treatments not Medically Necessary for the diagnosis and/or treatment of an active Sickness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value; or drugs not approved for use by the U.S. Food and Drug Administration;

11. charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;

12. hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, immunizations or tests not connected with the actual Sickness or Injury, except as otherwise specified herein;

13. replacement of cataract lenses when a prescription change is not required or the prescribing and fitting of an artificial eye;

14. professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life, and unless such care is specifically listed as a benefit elsewhere in the Plan;

15. treatment of obesity;

16. diagnosis or treatment of infertility, or restoration or enhancement of fertility, including, but not limited to, therapeutic injections, fertility and other drugs, Surgery, artificial insemination, in-vitro fertilization;

17. professional services on an outpatient basis in connection with mental illness, alcoholism, drug addiction, functional nervous disorders, mental or nervous disorders of any type or cause, or for psychiatric or psychoanalytic care for any reason, when rendered by anyone not under the direct supervision of a Physician or psychologist;

18. IQ testing or educational testing;

19. vitamins or dietary supplements;

20. housekeeping or custodial care;

21. weak, unstable or flat feet, or bunions, unless an open cutting operation is performed; or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed; or purchase of orthopedic shoes or other devices for support of the feet;

22. treatment of temporomandibular joint (TMJ) syndrome in excess of the amount shown in the Schedule of Benefits, any jaw joint condition including craniomandibular disorders and all other conditions of the joint linking the jaw bone and skull and complex of muscles, nerves and other tissues relating to that joint;

23. enrollment in a health, athletic or similar club or weight loss, non-smoking or similar programs, except as otherwise specifically provided herein;

24. purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses or waterbeds;

25. purchase or rental of: motorized transportation equipment, escalators or elevators, saunas, steambaths, swimming pools or blood pressure kits;

26. sex transformation and hormones related to such treatment;

27. radial keratotomy, keratoplasty or other eye Surgery to correct near- or far-sightedness;

28. chelation therapy;

29. sterilization procedures, except tubal ligation or vasectomy, or reversal of sterilization;

30. abortions, unless Medically Necessary;

31. benefits mandated by court order or decree, except where specifically required by applicable law;

32. any limitations on benefits contained in the Schedule of Benefits;

33. services and supplies not specifically mentioned in the Plan;

34. hair prosthesis, including wigs and hair pieces;

35. religious, sexual, marital and family counseling;

36. Expenses Incurred for special education or training for learning disabilities;

37. Expenses Incurred for behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness; or

38. any taxes or other assessments owed with respect to Expense Incurred for medical services (other than sales tax);

D. for "experimental treatment" for a Covered Person or Covered Dependent. For the purpose of this Section, a treatment or procedure shall be deemed an "Experimental Treatment" when the treatment or procedure involved is given that designation or a similar designation in connection with the administration of Medicare. In addition, a transplant procedure shall be deemed an "Experimental Treatment" if it is not one of the procedures specified in the Transplant Benefits Section.

CONTINUATION OF BENEFITS

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions.

For the purpose of this Section, "Qualified Beneficiary" means any beneficiary defined as such pursuant to Section 607(3) of ERISA, and generally includes any Covered Person or Covered Dependent whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Section. A Qualified Beneficiary also includes a child who is born to, or placed for adoption with, the Covered Person during the continuation coverage elected under this Section, provided such child qualifies as an Eligible Dependent.

Domestic partners, Civil Union Partners and partners in a common-law marriage are **not** Qualified Beneficiaries under COBRA.

Eligibility to Make Election

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

A. the Covered Person's death;

B. termination of the Covered Person's employment or reduction of the Covered Person's hours (whether voluntarily or involuntarily);

C. divorce or legal separation of the Covered Person and his or her spouse;

D. the Covered Person becoming entitled to Medicare benefits;

E. a Covered Person's child ceasing to be an Eligible Dependent; or

F. a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer if the Covered Person is a retiree.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the Covered Person's termination of employment is for gross misconduct as determined by the Employer. In the case of bankruptcy proceedings as described in (F) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one year before or after the date of commencement of the proceedings.

Election Period and Procedure

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending 60 days after the later of (i) such date, or (ii) if applicable, under the Administrative Section, the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election, as described herein or in the Employer's notice of election, shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the Covered Person or his or her spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later make an election, unless the Qualified Beneficiary revokes the waiver within the 60-day election period described above. However, if a waiver is revoked, continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in the Eligibility to Make Election Section.

Benefits

A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person or Covered Dependent under similar circumstances is otherwise entitled. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Covered Person or Covered Dependent under similar circumstances.

Payment for Benefits

A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium which shall be described in the Employer's notice of election form. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium, and such Qualified Beneficiary shall be precluded from extending, renewing, or reelecting such continuation coverage.

Duration of Continuation Coverage

A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

A. the date 18 months after the date of a Covered Person's termination of employment or reduction in hours;

B. the date 36 months after the date of any other event described in the Eligibility to Make Election Section other than a Covered Person's termination of employment or reduction in hours (except that if a Covered Person who is an Employee has a termination of employment or reduction in hours entitling him or her to continuation coverage after the date of his or her entitlement to Medicare, then the period of Continuation Coverage for the Qualified Beneficiaries other than the Covered Person shall not terminate prior to the close of the later of (i) the 36-month period beginning on the date the Covered Person became entitled to Medicare or (ii) 18 months [or 29 months if there is a disability extension) after the Employee's termination of employment or reduction in hours]);

C. the date the Employer ceases to provide any health benefit plan for any of its employees;

D. the date the Qualified Beneficiary first becomes covered after the date of his or her election of continuation coverage (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;

E. the date which is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (regardless of any grace period if the Employer establishes such a period) as determined by the Employer; or

F. in the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act ("Act"), to have been disabled at any time during the first 60 days of continuation coverage, the earlier of (i) the date 29 months after the date of the commencement of such continuation coverage (but only if the Qualified Beneficiary has provided notice of such determination under ERISA Section

606(3) within 60 days of the receipt of the determination notice under the Act and before the expiration of 18 months from the date of occurrence of the qualifying event) or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in the Eligibility to Make Election Section herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section. In addition, the maximum period available for continuation coverage pursuant to the Continuation of Benefits Section is measured from the date of occurrence of the qualifying event specified in the Eligibility to Make Election Section, except where specifically indicated to the contrary.

Administration

A. Notice on Death, Termination, Reduction of Hours or Entitlement to Medicare

Within 30 days of a Covered Person's death, termination of service, reduction of hours or entitlement to Medicare, the Employer shall inform the Plan Administrator of:

1. the Qualified Beneficiaries eligible to elect continuation coverage;

2. the event precipitating such notice; and

3. the date of the event.

The COBRA Notice Coordinator or Plan Administrator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect continuation coverage pursuant to procedures established by the Employer and applicable law.

B. Notice of Change in Marital Status or Dependent Status

If a Covered Dependent ceases to be eligible for coverage under the Plan because that person becomes divorced or legally separated from the Covered Person, or if a child of a Covered Person ceases to be eligible for coverage under the Plan because he or she is no longer an Eligible Dependent, either the Covered Person, the Covered Person's former spouse or the Covered Person's child must notify the COBRA Notice Coordinator or Plan Administrator of these events within 60 days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. The notice may be provided to the COBRA Notice Coordinator or Plan Administrator orally or in writing and must disclose:

1. the name and Plan identification numbers of the Covered Person and the individuals affected by the event;

2. proof of the individual's divorce, separation or loss of status as an Eligible Dependent; and

3. the date of such event.

Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce, legal separation or change in Dependent status, the COBRA Notice Coordinator or Plan Administrator, if notified within the time period specified in this subsection (B), shall notify the Qualified Beneficiaries of their eligibility to elect continuation coverage.

C. Notice of Disability

If a Covered Person or Covered Dependent is determined, under Title II or XVI of the Act to have been disabled at any time during the first 60 days of continuation coverage, the Covered Person or Covered

Dependent, as the case may be, must notify the COBRA Notice Coordinator or Plan Administrator of the determination under the Act within 60 days of the latest of the following to occur:

1. The date of the Social Security Administration disability determination (sometimes referred to as the "award letter");

2. The date of the termination of employment or reduction in hours entitling the Qualified Beneficiary to COBRA continuation coverage;

3. The date the Qualified Beneficiary otherwise loses coverage under the Plan as a result of the termination of employment or reduction in hours; or

4. The date the Qualified Beneficiary is informed of the obligation to provide notice of disability as provided herein.

Notwithstanding the above, the notice of determination must be provided to the COBRA Notice Coordinator or Plan Administrator before the expiration of 18 months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the COBRA Notice Coordinator or Plan Administrator in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person or Covered Dependent. The Qualified Beneficiaries must also notify the COBRA Notice Coordinator or Plan Administrator in writing within 30 days of the date of any final determination under the Act that the Covered Person or Covered Dependent is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

D. Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Qualified Beneficiary (i) becomes covered (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or (ii) becomes entitled to benefits under Medicare, the Qualified Beneficiary must notify the COBRA Notice Coordinator or Plan Administrator of such event in writing within 30 days of such coverage date.

E. General

1. Multiple Events. If more than one event described in the Eligibility to Make Election Section occurs, the first such event occurring will determine which one of either Subsection (A) or (B) of this Section is applicable.

2. Notices to Employer. Notices to the COBRA Notice Coordinator shall be provided to the COBRA Notice Coordinator listed in the General Information section. If no COBRA Notice Coordinator is listed in the General Information section, then the Employer shall be considered the COBRA Notice Coordinator and notices shall be provided to the person or organizational unit of the Employer that customarily handles employee benefit matters of the Employer.

3. Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary's last known address. As a result, it is important for each Covered Person and Covered Dependent to provide the Employer in a timely manner with his or her current mailing address.

4. Interpretation. In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted and administered in a manner which meets the minimum requirements of COBRA.

OTHER CONTINUATION OF BENEFITS RIGHTS

Definitions. For purposes of this Section, the following definitions apply:

"Dependent" means a child of the Employee's Partner who is not the Employee's natural child, step child, legally adopted child, a child placed with the Employee for adoption or any child for whom the Employee's Civil Union Partner, pursuant to court order or decree, is responsible for healthcare expenses, and who is covered under the Plan.

"Partner" means an Employee's covered Civil Union partner.

Other Continuation of Benefits Administration. The Plan Administrator is Heart of Illinois Educators Association, 100 Hillcrest Drive, Washington, IL 61571. Continuation of benefits coverage for this Plan is administered by the Contract Administrator. Complete instructions on the continuation coverage, as well as election forms and other information, will be provided by the Plan Administrator or the Contract Administrator to Plan participants who are eligible for continuation of benefits under this Section.

Eligibility to Make Election

Civil Union Partners (and the Partner's covered Dependents who do not meet the COBRA definition of a Qualified Beneficiary) may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

A. the Covered Person's death;

B. termination of the Covered Person's employment or reduction of the Covered Person's hours (whether voluntary or involuntary);

C. dissolution of the Civil Union or legal separation of the Covered Person and his/her Partner;

D. the Covered Person becoming entitled to Medicare benefits;

E. a Partner's child ceasing to be an Eligible Dependent; or

F. a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer if the Covered Person is a retiree.

Notwithstanding the above, a Partner/Dependent is not entitled to elect continuation coverage if the Covered Person's termination of employment is for gross misconduct as determined by the Employer. In the case of bankruptcy proceedings as described in (F) above, a loss of coverage includes a substantial elimination of coverage with respect to a Partner/Dependent within one year before or after the date of commencement of the proceedings.

Election Period and Procedure

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending 60 days after the later of (i) such date, or (ii) if applicable, under the Administrative Section, the date when the Partner/Dependent is notified of the right to make such election. A Partner's/Dependent's failure to comply with the procedures and requirements established by the Employer for making the election, as described herein or in the Employer's notice of election, shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Partner/Dependent (or by the Covered Person or his or her Partner on behalf of a Dependent) of the election to continue coverage shall terminate the Partner's/Dependent's right to later make an election, unless the Partner/Dependent revokes the waiver within the 60-day election period described above. However, if a waiver is revoked,

continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in the Eligibility to Make Election Section.

Benefits

A Partner/Dependent who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person or Covered Dependent under similar circumstances is otherwise entitled. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Partner's/Dependent's election of continuation coverage, each individual will be entitled to benefits comparable to those available to a Covered Person or Covered Dependent under similar circumstances.

Payment for Benefits

A Partner/Dependent is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Partners/Dependents shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium which shall be described in the Employer's notice of election form. A Partner's/Dependent's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium, and such Partner/Dependent shall be precluded from extending, renewing, or reelecting such continuation coverage.

Duration of Continuation Coverage

A Partner/Dependent electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

A. the date 18 months after the date of a Covered Person's termination of employment or reduction in hours;

B. the date 36 months after the date of any other event described in the Eligibility to Make Election Section other than a Covered Person's termination of employment or reduction in hours (except that if a Covered Person who is an Employee has a termination of employment or reduction in hours entitling him or her to continuation coverage after the date of his or her entitlement to Medicare, then the period of Continuation Coverage for the Partner/Dependents other than the Covered Person shall not terminate prior to the close of the later of (i) the 36-month period beginning on the date the Covered Person became entitled to Medicare or (ii) 18 months [or 29 months if there is a disability extension] after the Employee's termination of employment or reduction in hours);

C. the date the Employer ceases to provide any health benefit plan for any of its Employees;

D. the date the Partner/Dependent first becomes covered after the date of his or her election of continuation coverage (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any Preexisting Condition of such Partner/Dependent, or the date the Partner/Dependent becomes entitled to benefits under Medicare;

E. the date which is the last day of the period for which the Partner's/Dependent's Continuation Premium payments have been paid (regardless of any grace period if the Employer establishes such a period) as determined by the Employer; or

F. in the case of a Partner/Dependent who is determined, under Title II or XVI of the Social Security Act ("Act"), to have been disabled at any time during the first 60 days of continuation coverage, the earlier of (i) the date 29 months after the date of the commencement of such continuation coverage (but only if the Partner/Dependent has provided notice of such determination within 60 days of the receipt of the

determination notice under the Act and before the expiration of 18 months from the date of occurrence of the qualifying event) or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Partner/Dependent is no longer disabled.

If more than one event that would entitle the Partner/Dependent to elect continuation coverage occurs (as described in the Eligibility to Make Election Section herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section. In addition, the maximum period available for continuation coverage pursuant to the Other Continuation Rights Section is measured from the date of occurrence of the qualifying event specified in the Eligibility to Make Election Section, except where specifically indicated to the contrary.

Administration

A. Notice on Death, Termination, Reduction of Hours or Entitlement to Medicare

Within 30 days of a Covered Person's death, termination of service, reduction of hours or entitlement to Medicare, the Employer shall inform the Plan Administrator of:

1. the Partner's/Dependent's eligible to elect continuation coverage;

2. the event precipitating such notice; and

3. the date of the event.

The Plan Administrator, at the direction of the Employer, shall then notify the Partner/Dependents of their rights to elect continuation coverage pursuant to procedures established by the Employer and applicable law.

B. Notice of Change in Civil Union Status or Dependent Status

If a Partner ceases to be eligible for coverage under the Plan because that person becomes legally separated from the Covered Person or the Civil Union is dissolved, or if a child of a Covered Partner ceases to be eligible for coverage under the Plan because he or she is no longer an Eligible Dependent, either the Covered Person, the Covered Person's former Partner or the Partner's child must notify the Plan Administrator of these events within 60 days of their occurrence in order for the respective Partner/Dependent to be eligible to elect continuation coverage. The notice may be provided to the Plan Administrator orally or in writing and must disclose:

1. the name and Plan identification numbers of the Covered Person and the individuals affected by the event;

2. proof of the dissolution of the Civil Union, separation or loss of status as an Eligible Dependent; and

3. the date of such event.

Notice by an Employee/Partner/Dependent of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of the dissolution of the Civil Union, legal separation or change in Dependent status, the Plan Administrator, if notified within the time period specified in this subsection, shall notify the Partner/Dependents of their eligibility to elect continuation coverage.

C. Notice of Disability

If a Covered Person or Covered Partner/Dependent is determined, under Title II or XVI of the Act to have been disabled at any time during the first 60 days of continuation coverage, the Covered Person or Covered Partner/Dependent, as the case may be, must notify the Plan Administrator of the determination under the Act

within 60 days of the latest of the following to occur:

1. The date of the Social Security Administration disability determination (sometimes referred to as the "award letter");

2. The date of the termination of employment or reduction in hours entitling the Partner/Dependent to other continuation coverage;

3. The date the Partner/Dependent otherwise loses coverage under the Plan as a result of the termination of the Covered Person's employment or reduction in hours; or

4. The date the Partner/Dependent is informed of the obligation to provide notice of disability as provided herein.

Notwithstanding the above, the notice of determination must be provided to the Plan Administrator before the expiration of 18 months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the Plan Administrator in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Partner/ Dependent, and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person or Covered Partner/Dependent. The Covered Person of Covered Partner/Dependent must also notify the Plan Administrator in writing within 30 days of the date of any final determination under the Act that the Covered Person or Covered Partner/Dependent is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Partner/Dependent, and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

D. Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Partner/Dependent (i) becomes covered (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any Preexisting Condition of such Partner/Dependent, or (ii) becomes entitled to benefits under Medicare, the Partner/Dependent must notify the Plan Administrator of such event in writing within 30 days of such coverage date.

E. General

1. Multiple Events. If more than one event described in the Eligibility to Make Election Section occurs, the first such event occurring will determine which one of either Subsection (A) or (B) of this Section is applicable.

2. Notices to Employer. Notices to shall be provided to the person or organizational unit of the Employer that customarily handles employee benefit matters of the Employer.

3. Current Addresses. The notification of election rights will generally be made by U.S. Mail to the Partner's/Dependent's last known address. As a result, it is important for each Covered Person and Covered Partner/Dependent to provide in a timely manner the Employer with his or her current mailing address.

IMRF CONTINUATION OF BENEFITS

Notwithstanding any provision herein to the contrary, each Employer shall offer continuation benefits to each Covered Person who is a participant in the Illinois Municipal Retirement Fund ("IMRF Employee"), or his or her Covered Dependents, whose coverage under the Plan would otherwise terminate due to his or her termination of employment. Continuation coverage pursuant to this Section shall be available only during the Retirement or Disability Period as defined below.

As used in this Section, "Retirement or Disability Period" refers to the period of time:

A. which begins on the day the IMRF Employee is removed from the Employer's payroll because of the occurrence of either of the following events:

   1. the IMRF Employee retires from active service as an Employee with an attained age and accumulated creditable service which together qualify the IMRF Employee for immediate receipt of retirement pension benefits under the Illinois Municipal Retirement Fund ("IMRF"), or

   2. the IMRF Employee's disability is established under IMRF; and

B. which ends on the first to occur of any of the following events:

   1. the IMRF Employee's reinstatement or reentry into active service as provided for under the files of IMRF;

   2. the IMRF Employee's exercise of any refund option or acceptance of any separation benefit available under IMRF;

   3. the IMRF Employee's loss of IMRF benefits as a result of a felony conviction in accordance with 40 ILCS 5/7-219;

   4. the IMRF Employee's death, or if at the time of the IMRF Employee's death, the IMRF Employee is survived by a spouse/Civil Union Partner who, in that capacity, is entitled to receive a surviving spouse/Civil Union Partner monthly pension benefit under IMRF;

   5. the death or remarriage of that spouse;

   6. the death or re-Civil Union of that Civil Union Partner;

   7. the IMRF Employee's becoming eligible for benefits under Medicare, or

   8. the IMRF Employee's failure to pay any required contribution for coverage.

Upon receipt of notification of the intent of an IMRF Employee to elect continuation coverage, the COBRA Notice Coordinator shall notify the IMRF Employee of the election procedure and provide the necessary forms to make the election. The COBRA Notice Coordinator shall also provide a calculation of the cost to the IMRF Employee of maintaining the continuation coverage.

The Covered Person and/or his or her Covered Dependents is required to pay the entire cost of such continuation coverage computed at the same rate charged for equivalent coverage provided under the Plan with respect to Covered Persons and/or Covered Dependents whose Retirement or Disability Period has not begun.

Continuation of benefits in accordance with this Section shall be coordinated with, and is not in addition to, continuation of benefits available pursuant to the Extension of Benefits or Continuation of Benefits Sections or any other Section of this Plan.

MILITARY LEAVE

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions. Any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section described above.

Election and Duration of Coverage

A Covered Person may elect to continue coverage under the Plan for himself or herself and his/her Covered Dependents if coverage would otherwise cease under the Plan due to that person's absence from employment with the Employer by reason of his or her service in the uniformed services. The maximum period of coverage available to all Covered Persons and Covered Dependents under the provisions of this Section shall be the lesser of:

A. the 24-month period beginning on the date on which the Covered Person's military leave began; or

B. the day after the date on which the Covered Person fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.

Coverage elected under these circumstances is concurrent not cumulative. Only the Covered Person has election rights under USERRA. Dependents do not have any independent right to elect USERRA health plan continuation.

Benefits

Benefits under the Plan for Covered Persons and Covered Dependents under an election for military leave continuation coverage shall be the same coverage as provided to all other Covered Persons and Covered Dependents. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to, the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Covered Persons and Covered Dependents.

Payment for Benefits

A Covered Person is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Covered Person's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Covered Person shall be precluded from extending, renewing or reelecting such continuation coverage.

Employee Returning from Military Leave

In the case of a Covered Person whose coverage under the Plan was terminated by reason of service in the uniformed services, the Covered Person and his or her Eligible Dependents shall again be eligible for coverage under the Plan immediately upon return to active work. In addition, no other Plan limitation or exclusion shall apply to such returning Employee and his or her Eligible Dependents to the extent that such limitation or exclusion would not have applied had the Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

FAMILY AND MEDICAL LEAVE

In accordance with the Family and Medical Leave Act of 1993 (FMLA), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions.

A Covered Person who takes a Leave of Absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for himself or herself and his/her Covered Dependents. Benefits under the Plan are available to the same extent as if the Covered Person had been actively at work during the entire leave period, subject to the following terms and conditions:

A. Coverage shall cease for a Covered Person (and his or her Covered Dependents) for the duration of the leave if at any time the Covered Person is more than 30 days late in paying any required contribution.

B. A Covered Person who declines coverage during the leave or whose coverage is terminated as a result of his or her failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination or exclusion of pre-existing conditions.

C. If a Covered Person who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his or her reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the Covered Person advises the Employer that he or she does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

D. Any portion of the cost of coverage which had been paid by the Covered Person prior to the leave must continue to be paid by the Covered Person during the leave. If the cost is raised or lowered during the leave, the Covered Person shall pay the new rates. If the leave is unpaid, the Covered Person and the Employer shall negotiate a reasonable means for paying the Covered Person's portion of the cost.

E. If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Covered Person is on leave, the Covered Person is entitled to the new or changed plan and benefits to the same extent as if the Covered Person were not on leave.

F. The Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Covered Person fails to return to work after the Covered Person's leave entitlement has been exhausted or expires, unless the reason the Covered Person does not return to work is due to (i) the continuation, recurrence or onset of a serious health condition which would entitle the Covered Person to additional leave under the FMLA; or (ii) other circumstances beyond the Covered Person's control. If a Covered Person fails to return to work because of the continuation, recurrence or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Covered Person's behalf during a period of unpaid leave, the Employer may require medical certification of the Covered Person's or the Covered Dependent's serious health condition. The Covered Person is required to provide medical certification within 30 days from the date of the Employer's request. If the Employer requests medical certification and the Covered Person does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.

MISCELLANEOUS

Nonalienation of Benefits

Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse/Civil Union Partner or former spouse/Civil Union Partner or for any other relative of a Covered Person or Covered Dependent, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder, shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Invalid Provision

If any term or provision of this Plan or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

Governing Law

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois where it has been executed, except where preempted by federal law.

Amendment/Termination

It is the intention of the Employer to maintain the Plan indefinitely. However, the Employer may amend or terminate the Plan at any time, provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a Covered Person or Covered Dependent shall have become entitled prior to such amendment or termination of the Plan.

Exclusive Benefit/Legal Enforceability

The Plan has been established and is being maintained for the exclusive benefit of the Employees of the Employer. The Plan terms, as provided herein, are legally enforceable by the Employees.

Action by Association

Any action by the Association under this Plan, including an action to amend or terminate the Plan, may be made by resolution of the Board of the Association, or by action of any person or persons duly authorized by the Board of the Association to take such action.

INTERPRETATION OF THE PLAN

Final authority for interpretation of the terms and provisions of the Plan is vested in the Employer. Any interpretation so required by the Employer shall be made in good faith, subject to reasonable care and prudence, and all such interpretations are final. The Employer shall have discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

FIDUCIARY RESPONSIBILITIES

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties8

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Eligible Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

A. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

B. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

C. in accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

A. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

B. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Contract Administrator is Not a Fiduciary

A Contract Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

DEFINITIONS

Where the following words and phrases appear in this Plan, they shall have the respective meanings as set forth in this Section, unless the context clearly indicates to the contrary.

The words "hereof," "herein," "hereunder" and other similar compounds of the word "here" shall mean and refer to the entire Plan and not to any particular provision or Section.

Ambulatory Surgical Facility: means any public or private establishment, which is either independent or part of a Hospital, with:

1. an organized medical staff of Physicians;

2. permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

3. continuous Physician and Registered Nursing services whenever a patient is in the facility; and

4. no provision of services or other accommodations for patients to stay overnight.

Ambulatory Surgical Facility does not include an office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy.

Birthing Center: means an entity licensed, approved or authorized to provide treatment for persons during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. Such entity must:

1. provide skilled nursing care by or under the supervision of Registered Nurses;

2. be staffed and equipped to provide Emergency Treatment; and

3. have written back-up arrangements with a local Hospital to provide follow-up Emergency Treatment.

Civil Union: means a legal relationship granted to unmarried adult Partners by the State of Illinois. A substantially similar legal relationship (other than common law marriage) legally entered into in another jurisdiction when recognized by the State of Illinois shall also be considered a Civil Union.

Covered Dependent: means an Eligible Dependent of any Covered Person for whom coverage became effective and has not terminated.

Covered Person: means an eligible Employee whose coverage under the Plan became effective and has not terminated.

Creditable Coverage: means coverage of the Covered Person or Covered Dependent under any of the following:

1. a group health plan;
2. health insurance coverage;
3. Part A or B of Medicare;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10, United States Code;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a health plan offered under Chapter 89 of Title 5 of the United States Code;
8. a state health benefits risk pool;

9. a public health plan;
10. a health benefit plan under Section 5(e) of the Peace Corps Act;
11. Title XXI of the Social Security Act; or
12. a State Child Health Insurance Program (SCHIP).

Creditable Coverage shall not include coverage consisting solely of excepted benefits under the Health Insurance Portability and Accountability Act of 1996, including coverage solely for limited-scope dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break in coverage of more than 63 days. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade-related coverage loss and the start of a special second COBRA election period under the Trade Act, does not count.

Dental Services: means care and treatment of the teeth and gums, or any services rendered by a dentist or dental surgeon.

Eligible Dependent: means an Employee's:

1. spouse; The term "spouse" shall mean a person of the opposite sex recognized as the covered Employee's husband or wife in a lawful marriage recognized by the State in which the Employee resides, and who is neither divorced nor legally separated from the Employee. The term "spouse" shall **not** include partners in a Civil Union, a common law marriage or a domestic relationship. The term "marriage" means only a legal union between one man and one woman as husband and wife.

   The Plan Administrator may require documentation proving a legally recognized marriage.

2. Civil Union Partner; The term" Civil Union" means a legal relationship granted to unmarried adult Partners by the State of Illinois. A substantially similar legal relationship (other than common-law marriage) legally entered into in another jurisdiction when recognized by the State of Illinois shall also be considered a Civil Union.

   The Plan Administrator may require documentation proving a legally recognized Civil Union.

3. child; An Employee's "child" includes his or her natural child, stepchild, adopted child, a child placed with the Employee for adoption or any child for whom the Employee or Employee's spouse, pursuant to court order or decree, is responsible for healthcare expenses. An Employee's child will be an Eligible Dependent until reaching the limiting age of 26 years, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the child's birthday.

   The phrase "placed for adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 years as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

4. qualified dependent child;

   a. A Civil Union Partner's natural child, adopted child, child placed with the Civil Union Partner for adoption or any child for whom the Civil Union Partner, pursuant to court order or decree, is responsible for healthcare expenses. A Civil Union Partner's child will be an Eligible Dependent until reaching the limiting age of 26 years, without regard to student status, marital status, financial dependency or residency status with the Civil Union Partner

or any other person. When the child reaches the applicable limiting age, coverage will end on the child's birthday.

b. An Employee's child or the child of a Civil Union Partner who is unmarried and over age 26 years but less than 30 years of age if a Military Veteran. The term "Military Veteran" shall mean an Illinois resident who served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States (including the National Guard) who has received a release or discharge other than a dishonorable discharge. To be considered a Military Veteran by the Plan, the eligible child who is a veteran must submit to the Plan Administrator or Contract Administrator a form approved by the Illinois Department of Veterans' Affairs stating the date on which the veteran was released from service. A qualified dependent who is a Military Veteran will be an Eligible Dependent until reaching the limiting age of 30 years;

5. child who is the subject of a Qualified Medical Child Support Order (QMCSO) or other court Order for Support, wherein it directs the Covered Person to provide medical coverage (see the section titled "Qualified Medical Child Support Order").

   Any child of a Covered Person who is an alternate recipient under a QMCSO shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied.

   A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

   The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

6. any unmarried child 26 years of age or over who is incapable of self-sustaining employment by reason of mental or physical handicap, and who is chiefly dependent upon the Employee for support and maintenance, provided the child is suffering from such disability on the date he or she otherwise ceases to be eligible for benefits under the Plan (also see the Section titled "Extension of Benefits, Disabled Child").

The definition of an Eligible Dependent shall exclude the following:

1. any person who is not a resident within the United States of America or Canada;

2. any person who is covered under this Plan as an Employee or IMRF Employee;

3. any spouse, Civil Union Partner and/or qualified dependent child who is on active duty in any military, naval, or air force of any country;

4. any spouse of an Employee or IMRF Employee who is legally separated or divorced from the Employee;

5. any Civil Union Partner from whom the Employee or IMRF Employee is legally separated or has received a dissolution of the partnership;

6. any child of a Civil Union Partner from whom the Employee or IMRF Retiree is legally separated or has received a dissolution of the partnership; and

7. other individuals living in the covered Employee's or IMRF Employee's home, but who are not eligible as defined.

At any time, the Employer or the Plan may require proof that an individual continues to qualify as an Eligible Dependent herein.

Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing his or her health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency Services: means a medical screening examination (as required under Section 1867 of the Social Security Act [EMTALA]) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a medical emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

"Stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

It shall not include treatment of symptoms of a chronic condition unless such symptoms are sudden, unexpected and severe.

Employee: means a person employed by the Heart of Illinois Educators Association.

Employer: means any of the educational institutions in the districts which compromise the Association through which the Plan is established and the Plan Sponsor.

Essential Health Benefits: means, to the extent they are covered under the Plan, 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). Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulation issued pursuant thereto. Substance Abuse – Inpatient Treatment and Autism Spectrum Disorders are not Essential Benefits.

Expenses Incurred: means charges for purchases or services rendered. An expense will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the charge is made.

Experimental Treatment: means drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments or services which do not meet accepted standards of medical practice. A drug, device, treatment, or procedure is considered to be Experimental and/or investigational:

1. if the device, drug, treatment, or procedure has not received the approval or endorsement of the American Medical Association (AMA), U.S. Food and Drug Administration (FDA) or the National Institute of Health (NIH) at the time the device, drug, or procedure was furnished; or

2. if reliable evidence demonstrated that the device, drug, treatment, or procedure is the subject of ongoing Phase I, II, or III Clinical Trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment or diagnosis;

3. if reliable evidence demonstrates that a consensus of opinion among medical experts regarding the device, drug, treatment or procedure is that further studies or Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard of treatment or diagnosis; or

4. when the treatment or procedure involved is given that designation or a similar designation in connection with the administration of Medicare.

In addition, a transplant procedure shall be deemed an "Experimental Treatment" if it is not one of the procedures specified in the Transplant Benefits Section.

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

Full-Time Employee: means a person who is scheduled to work on a full-time basis, as determined pursuant to the regular employment policies of each Employer.

Genetic Information: means information about genes, gene products and inherited characteristics that may be derived from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. The definition also includes information derived from an individual's genetic tests; the genetic tests of the individual's family members (first- through fourth-degree relatives); and the manifestation of a condition in the individual's family members. Genetic information also includes the individual's request for, receipt of, or participation in, clinical research for genetic services (tests, counseling and education) and PKU, BRCA1 or BRCA2 tests.

With respect to a pregnant woman (or her family members), genetic information specifically includes information about the fetus she is carrying or any embryo legally held by the individual or a family member.

Genetic information does not include information about an individual's sex or age, a manifested condition that could reasonably be diagnosed by a medical professional, or analysis of proteins or metabolites directly related to a manifested condition.

Home Health Care Agency: means an organization, or its distinct part, which:

1. is primarily engaged in providing skilled nursing care and other therapeutic services for, and in the private residences of, persons recovering from Sickness or Injury;

2. qualifies as a home health care agency under Medicare and is licensed or approved according to any applicable state or local standards and is operated pursuant to policies established by a professional staff, including at least one Physician and one Registered Nurse;

3. provides full-time supervision of its services by a Physician or Registered Nurse and maintains clinical records on all of its patients;

4. has a full-time administrator; and

5. is not, other than incidentally, engaged in providing care or treatment of the mentally ill or in providing custodial-type care.

Home Health Care Plan: means a program of continued care and treatment for a Covered Person or Covered Dependent, established and approved in writing by the Physician of the Covered Person or Covered Dependent. The program must be accompanied by the Physician's certification that the proper treatment of the Sickness or Injury would require confinement as a Hospital inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice: means an entity licensed, approved or authorized to provide inpatient and at-home medical relief of pain and supportive care to terminally ill persons. An inpatient facility must have on its premises:

1. organized facilities to care for and treat terminally ill persons; and

2. a paid staff of medical professionals to supervise such care and treatment.

However, a Hospital or Skilled Nursing Facility shall not be considered a Hospice.

Hospital: means an institution constituted and operated in accordance with the laws pertaining to Hospitals, equipped with permanent facilities for diagnosis, Surgery, 24-hour continuous nursing service by Registered Nurses, and a staff of one or more Physicians licensed to practice medicine available at all times for compensation, and provides for medical and surgical treatment for Injury and Sickness on an inpatient basis. The term "Hospital" does not include a facility specializing in dentistry or an institution which is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a convalescent home or a nursing home.

Hospital Confinement/Admission: means being registered as a bed patient in a Hospital upon the recommendation of a Physician, or as a patient in a Hospital because of a surgical operation, or as a patient receiving emergency care in a Hospital for an Injury.

Immediate Family: means a person's spouse/Civil Union Partner, children, grandchildren, parents and siblings.

Injury: means accidental bodily injury of a Covered Person or Covered Dependent. All Injuries sustained by a Covered Person or Covered Dependent in connection with a single accident shall be considered one Injury.

Intensive Care Unit: means a section, ward or wing within the Hospital which is separated from other Hospital facilities and:

1. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;

2. has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and

3. provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Key Employee: means a salaried Employee eligible for leave under the Family and Medical Leave Act of 1993 who is among the highest paid 10 percent of all the Employees employed by the Employer within 75 miles of the Employee's worksite.

Leave of Absence: means any absence authorized by the Employer under the Employer's standard personnel practices provided that all persons under similar circumstances must be treated alike in the granting of such Leave of Absence and provided further that the Employee returns within the period of authorized absence.

Licensed Practical Nurse: means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing service by the state in which he or she performs such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Licensed Social Worker: means a person who is duly licensed in the state where he or she is practicing who provides social services to individuals in the fields of social casework and social group work. Social casework and social group work may also include clinical social work as long as it is conducted under the supervision of a Physician or psychologist.

Medical Care: means services rendered by a Physician for treatment of Sickness or Injury during a visit to a Physician's office or during a visit by a Physician to a Covered Person or Covered Dependent:

1. when the Covered Person or Covered Dependent is a patient in a Hospital or Skilled Nursing Facility;

2. when the Covered Person or Covered Dependent is a patient in a Partial Hospitalization Treatment Program; or

3. when calling on the Covered Person or Covered Dependent at home.

Medically Necessary: means health care services, supplies or treatment which, in the judgment of the Employer, are 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 Illness: means those illnesses classified as mental disorders in Section II of the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

Necessary Services and Supplies: means any charge made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any Hospital Confinement/Admission other than charges for Room and Board, Intensive Care Unit, private duty nursing or Physician's services.

Nurse Practitioner: means a Registered Nurse licensed to provide basic primary health care and diagnose and treat acute Sickness and Injuries and who is providing such services within the scope and limitation of that license.

Oral Surgery: means:

1. Surgical removal of impacted teeth; and

2. Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth, provided that the procedures are rendered within 12 months of the accident.

Outpatient Self-Management Training and Education: means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications and instruction in understanding nutrient needs relative to medically prescribed diets, including tube feedings, specialized intravenous solutions, and specialized oral feedings, and food and prescription drug interactions. Diabetes Self-Management Training and Education shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition.

Outpatient Treatment: means treatment at a Hospital not requiring confinement and not involving a charge for Room and Board.

Partner: means an Employee's covered Civil Union partner.

Patient Protection and Affordable Care Act of 2010: means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Physician: means a practitioner of the healing arts who is duly licensed in the state where he or she is practicing and who is treating within the scope and limitation of that license. The term Physician will not include the Covered Person, nor his or her spouse/Civil Union Partner, children, brothers, sisters, or parents or any other person residing in his or her household.

Physician Assistant: means a practitioner who is formally trained and licensed to provide diagnostic, therapeutic and preventative health care services as delegated by a Physician and who is providing such services within the scope and limitation of that license.

Post-Service Claim: means any claim for a benefit under the Plan that is not a Pre-Service Claim or an Urgent Care Claim.

Pre-Existing Condition: means a condition for which a medical expenses were incurred or for which such person received medical care, treatment, consultation, diagnosis, diagnostic testing, advice, services, supplies or took prescribed drugs or medications, during the 3-month period ending on the Eligibility Date of such person's coverage under the Plan, or on the first day of a waiting period for coverage, if earlier. Genetic Information is not, by itself, a condition. Pregnancy is not a Pre-Existing Condition. A waiting period shall mean the period that must pass with respect to an individual before the individual is eligible for benefits under the Plan. Pre-Existing Condition limitations do not apply to Covered Persons or Covered Dependents under age 19 years.

Pre-Service Claim: means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of receiving medical care.

Rescission: means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if: (i) the cancellation or discontinuance has only a prospective effect; or (ii) the cancellation or discontinuance is attributable to the failure to timely pay required contributions.

Reasonable and Customary: means charges made for medical services and/or supplies essential to the care of an individual which are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received for Sickness or Injury comparable in severity to the Sickness or Injury being treated.

Registered Nurse: means a professional nurse who has the right to use the title Registered Nurse (RN) other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Room and Board: means all charges commonly made by a Hospital or other facility on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Sickness: means disease, mental, emotional or nervous disorders of a Covered Person or Covered Dependent. It also includes the pregnancy of a Covered Person or Covered Dependent.

Skilled Nursing Facility: means an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness, and:

1. is approved by and is a participating Skilled Nursing Facility of Medicare;

2. has organized facilities for medical treatment and provides 24-hour nursing service under the full-time supervision of a Physician or Registered Nurse;

3. maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and

4. has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

This definition does not include an institution operated primarily for care of the aged, or for treatment of mental disease, drug addiction, alcoholism or custodial care.

Substance Abuse: means uncontrollable or excessive abuse of any addictive substance and the resultant physiological or psychological dependence which develops with continued use, requiring medical treatment as determined by a Physician.

Substance Abuse Treatment Facility: means a facility (other than a Hospital) whose primary function is the treatment of alcohol and Substance Abuse and which is duly licensed by the appropriate state and local authority to provide such services.

Supplemental Accident Care: means services rendered subsequent to and as a result of an Injury for which a Covered Person or Covered Dependent received Emergency Services. Care will only be considered Supplemental Accident Care if it is rendered within 90 days of the date of the Injury.

Surgery: means operative or cutting procedures including specialized instrumentations and the correction of fractures or complete dislocations.

Total Disability: means a Sickness or Injury which:

1. with respect to a Covered Person, prevents that person from doing each of the main duties of that person's occupation with an Employer; and

2. with respect to a Covered Dependent, prevents that person from performing the normal activities of a healthy person of the same age and sex.

Urgent Care Claim: means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,

2. in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a Physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as such by the Plan.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

A. Receive Information about Their Plan and Benefits

1. Examine, without charge, at the plan administrator's office and at other specified locations (such as worksites and union halls) all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;

2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

1. continue health care coverage for yourself, spouse/Civil Union Partner or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights;

2. reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

D. Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials

and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

E. Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) 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).

BY THIS AGREEMENT, the Heart of Illinois Educators Association Health Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Heart of Illinois Educators Association on or as of the day and year first below written.

HEART OF ILLINOIS EDUCATORS ASSOCIATION

By: D. Nick Tom

Its: Superintendent

Dated: 1-10-2012

ADDENDUM A

PRESCRIPTION DRUG CARD PLAN

BENEFITS

FOR

EMPLOYEES OF

HEART OF ILLINOIS EDUCATORS ASSOCIATION

TABLE OF CONTENTS

INTRODUCTION

The purpose of this Plan is to enable Eligible Persons to purchase Covered Drugs from a Pharmacy or through the Mail-Order Program by paying only a portion (the Copayment Amount) of the full price of the particular drug. Covered Drugs are purchased from a Pharmacy by presenting to the Pharmacy both a Prescription Order (unless a refill) for the Covered Drugs and an Identification Card. Covered Drugs are obtained from the Mail-Order Program by completing the Registration & Prescription Order Form available from the Plan Administrator or the Contract Administrator and mailing the form to the Pharmacy Benefit Manager. The Plan will be responsible for payment of all amounts in excess of the Copayment Amount. Without the Plan, Covered Drugs could only be purchased by paying full price, which in most cases would be more than the Copayment Amount.

Any questions, requests for forms or other inquiries regarding the coverage of a prescription drug may be directed to the Pharmacy Benefit Manager, the Plan Administrator or the Contract Administrator.

ELIGIBILITY AND PLAN PARTICIPATION

A. Eligibility Requirements

You and your Dependents will be eligible to participate in the Plan when you and your Dependents have satisfied the eligibility requirements for benefits under the terms of the Health Plan.

B. Participation

You and your Dependents will begin participation on the first day on which you and your Dependents have met the eligibility requirements. When you become a Participant in the Plan, the Employer will issue you an Identification Card. You must present your Identification Card at the time you purchase Covered Drugs from a Pharmacy in order to take advantage of this Plan's benefits.

DEFINITIONS

Code - means the Internal Revenue Code of 1986, as amended from time to time.

Copayment Amount - means the amount which an Eligible Person is required to pay for a Covered Drug in accordance with the Health Plan.

Covered Drug - means any Prescription Legend Drug and such other drugs covered by the Plan, when ordered by a Physician by means of a Prescription Order.

Dependent - means an individual who meets the definition of a Covered Dependent as set forth in the Health Plan.

Eligible Person - means an individual and/or his or her Dependents described in an Identification Card who are entitled to Covered Drug expense benefits in accordance with, and under the terms of, the Plan.

Employee - means a person employed by Heart of Illinois Educators Association.

Employer - means any of the educational institutions in the districts which compromise the Association through which the Health Plan is established.

Health Plan – means the Heart of Illinois Educators Association Health Benefit Plan.

Identification Card - means a card or cards issued as proof of eligibility for Covered Drug expense benefits in accordance with, and under the terms of, the Plan.

Participant - means an Employee who has satisfied the Eligibility Requirements and has elected to participate in the Plan. A "Participant" shall also include an IMRF Employee.

Pharmacy - means a pharmacy doing business as a licensed pharmacy under an applicable state license or registration number and which has entered into a Prescription Drug Agreement with the Pharmacy Benefit Manager.

Prescription Legend Drug - means any medicinal substance, the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend – "Caution: Federal Law prohibits dispensing without prescription."

Prescription Order - means a request for medication by a Physician.

Physician - means a doctor of medicine, a doctor of osteopathy, a doctor of dental surgery, a doctor of dental medicine or a podiatrist, who is legally licensed to prescribe medications within the scope of that license.

BENEFITS

Each Eligible Person may purchase Covered Drugs from a Pharmacy by presenting his or her Identification Card and paying the applicable Copayment Amount. Covered Drugs may be purchased from those Pharmacies listed on the Participating Pharmacy Listing, a copy of which may be reviewed at the location of the Plan Administrator or the Contract Administrator or at such other sites as the Plan deems necessary. Pharmacies may be added to or deleted from the Participating Pharmacy Listing from time to time. Covered Drugs are obtained from the Mail-Order Program by completing the Registration & Prescription Order Form available from the Plan Administrator, the Contract Administrator or the Pharmacy Benefit Manager and mailing the form to Pharmacy Benefit Manager.

Most Prescription Drugs are covered by this Plan when prescribed by a Physician in connection with Medically Necessary services. Some Prescription Drugs may require preauthorization and certain criteria to be met. Contact the Pharmacy Benefit Manager listed on your Plan ID card to determine whether a medication is covered, requires preauthorization or for information regarding the copayment/coinsurance amount for a particular medication.

Immunosuppressant Drugs to Prevent Organ or Tissue Rejection

A. A prescription for an immunosuppressant drug to prevent rejection of a transplanted organ or tissue, which indicates "may not substitute" on the prescription must be filled as written. However a substitution may be made, provided the prescribing Physician and the patient (or parent or guardian if the patient is a child) or the spouse/Civil Union Partner of a patient who is authorized to consent to the treatment of the person:

    a. has been properly notified; and

    b. documented consent is received.

B. Any applicable copayment, deductible, coinsurance or other charge shall remain the same for the Plan Year, unless another drug or formulation has been interchanged.

C. The Covered Person or Covered Dependent and his/her Physician shall be notified, in writing, at least 60 days prior to any formulary change that alters the terms of coverage or the discontinuance of coverage for a prescribed immunosuppressant drug that a patient is receiving. The written notification may be provided

when the patient requests a refill along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

PENALTIES FOR IMPROPER USE

Eligible Persons may not use their Identification Cards to obtain Covered Drugs after having received notification of the cancellation of their benefits or for persons other than Eligible Persons. Any Eligible Person who makes an improper use of his Identification Card may be guilty of a Class C misdemeanor in accordance with the provisions of Section 512-8(c) of the Illinois Insurance Code and may be liable to the Administrator or Employer for amounts the Plan has paid as a result of any improper use of his/her Identification Card.

The Plan may request such amounts be paid immediately, and, if not paid when due, may take appropriate action to recover such amounts.

CLAIMS

A. Filing a Claim

There may be certain instances in which an Eligible Person cannot use the Identification Card to receive prescription drug benefits from a Pharmacy. At those times, a claim may be submitted in accordance with the Claim Provisions Section set forth in the Health Plan for consideration of expenses incurred that exceed the Copayment Amount. The claim for prescription drug benefits must have the following information:

1. the name of the patient;
2. the Employee's name and Social Security number;
3. the name of the Pharmacy dispensing the drug;
4. the name, strength, and quantity of the drug dispensed;
5. the date the drug was dispensed; and
6. the price of the drug.

B. Denial of Claims

If your claim for benefits is denied, the Claim Provisions section of the Health Plan sets forth your rights regarding claims review procedures.

GENERAL

A. Questions/Forms/Information

Any questions, requests for forms or other inquiries may be directed to the Pharmacy Benefit Manager, the Plan Administrator or the Contract Administrator.

B. Nondiscrimination

It is the intent of the Employer that the Plan not discriminate in favor of any Employee or group of Employees. If the Employer determines that the Plan is discriminatory, the Employer shall select and exclude from coverage under the Plan such Participants or reduce the contributions and/or benefits of such Participants, as shall be necessary to comply with the nondiscrimination provisions of the Internal Revenue Code.

ADDENDUM B

BE HEALTHY –
USING YOUR PREVENTIVE CARE BENEFITS

FOR

EMPLOYEES OF

HEART OF ILLINOIS EDUCATORS ASSOCIATION

Be Healthy – Using Your Preventive Care Benefits

Helping You Stay Healthy
Your Employer emphasizes prevention through comprehensive wellness coverage. The Contract Administrator supports coverage of these preventive services and is proud to administer them on your Employer's behalf.

The Plan covers preventive services and tests, when medically appropriate, even when you are healthy. Following is a partial list of the services included in your standard, comprehensive wellness benefit:

- **One wellness exam**, per member (no age limitations), per Calendar Year.
- **One visit to a Women's Principal Health Care Provider**, per year. Office visit Copayment or Coinsurance may apply and/or be applicable to a deductible.
- **Well-child care** (frequency based on American Association of Pediatricians (AAP) recommendations)
- **The screenings, procedures and immunizations** listed below, within the applicable wellness benefit:
    - Blood sugar screening (including a basic metabolic panel and comprehensive metabolic panel)
    - Cervical cancer screening (Pap smear)
    - Cervical cancer vaccine (ages 9 – 26)
    - Childhood immunizations (according to AAP guidelines)
    - Chlamydia screening
    - Cholesterol screening
    - Colorectal cancer screening* (flexible sigmoidoscopy, screening colonoscopy, fecal occult blood test)

A detailed listing of covered procedures and services follows.

Procedure Codes	Descriptions
Immunizations	
90696	DTaP-IPV (4-6 years)
90698	DTaP – Hib – IPV
90700	DTaP < 7 years
90701	DTP – diphtheria, tetanus & pertussis
90702	DT < 7 years
90719	Diphtheria toxoid
90720	DTP-Hib
90721	DTaP-Hib
90723	DTaP-HepB-IPV
90714	Td 7 years and older
90715	Tdap 7 years and older
90718	TD 7 years and older
90703	Tetanus toxoid
90632 - 90634	Hepatitis A
90636	HepA-HepB adult
90740, 90743, 90744, 90746, 90747	Hepatitis B
90748	HepB-Hib
90645-90648	Hib
90644, 90733-90734	Meningococcal
90649	HPV quadrivalent 3 dose
90655-90658, 90668, 90660-90664, 90666-90667	Influenza
90669-90670, 90732, S0195	Pneumococcal
90680-90681	Rotavirus
90704	Mumps
90706	Rubella

Procedure Codes	Descriptions
90705	Measles
90707	Measles, mumps & rubella MMR
90708	Measles and rubella
90710	Measles, mumps, rubella and varicella vaccine MMRV
90712-90713	Poliovirus (OPV or IPV)
90716	Varicella (VZV) – chicken pox
90736	Herpes Zoster (shingles) age 60 and older
G0008	Administration of influenza virus vaccine
G0009	Administration of pneumococcal vaccine
G0010	Administration of hepatitis B vaccine
G9141 – G9142, 90663	Influenza A (H1N1) immunization administration
90470	Administration of H1N1
90460-90461, 90471-90474	Immunization administration
Screenings	
Colorectal	
45378-45382, 45384-45387, 45391-45392, G0105, G0121	Colonoscopy
45330, G0104	Flexible Sigmoidoscopy
G0106, G0122	Barium enema
82270	Stool guaiac for colorectal neoplasm screening
82270, 82272, 82274, G0328	Blood occult
Bone Density	
76977	Ultrasound bone density scan (females 60 and older)
77078	CT bone mineral density study, axial (females 60 and older)
77080	DXA, bone density study
77083	X-ray absorptiometry (females 60 and older)
Cholesterol	
80061	Lipid profile (once every 5 years in men 35 and older, women 45 and older and women 20-45 at risk)
83718, 83721	Lipoprotein (once every 5 years in men 35 and older, women 45 and older and women 20-45 at risk)
82465	Cholesterol (once every 5 years in men 35 and older, women 45 and older and women 20-45 at risk)
84478	Triglycerides
Diabetes	
82947	Glucose (fasting blood sugar)
82950	Glucose, post prandial
82951	Glucose, tolerance test
Sexually Transmitted Diseases	
86592-86593	Syphilis test
87270, 87320, 87490- 87492, 87810	Chlamydia
87850, 87590-87592	Gonorrhoeae
87620-87622	Papillomavirus (HPV)
HIV	
86701	Antibiody, HIV-1
86702	Antibody, HIV-2
86703	Antibody, HIV-1 and HIV-2, single assay
G0432, G0433, G0435	Infection agent antibody detection
Miscellaneous	
85660	Sickle cell test (RBC)
G0117-G0118	Glaucoma screening
92551	Hearing screening, pure tone
80048	Basic metabolic panel
80053	Comprehensive metabolic panel
G0270-G0271, 97802-97804	Medical nutrition therapy

Procedure Codes	Descriptions
99173	Screening test of visual activity in children 5 and younger
85004	Blood count; automated differential WBC
96110	Developmental testing
99420	HRA administration & interpretation
Women's Health	
V72.31	Routine gynecological exam
P3000-P3001, Q0091, R923	Pap smear
G0101	Cervical or vaginal cancer screening, pelvic and breast exam
G0123-G0124, G0141, G0143-G0145, G0147-G0148	Screening cytopathology, cervical or vaginal
88141-88143, 88147-88148, 88150, 88152-88155, 88164-88167, 88174-88175	Cytopathology, cervical or vaginal
86304	Immunoassay for ovary tumor antigen
Mammography	
77052, 77057, G0202, R403	Screening mammography
96040	Medical genetics counseling (for BRCA)
Men's Health	
G0102-G0103	Prostate cancer screening
84152-84154	Prostate specific antigen
G0389	Ultrasound AAA screening (men age 65-75 who have ever smoked)
Smoking Cessation	
99406-99407	Smoking and tobacco use cessation counseling visit
Preventive Care Exams	
99381-99387, 99391-99397	Preventive Medicine Services
99401-99404, 99411-99412	Preventive counseling
R770	Preventive Care Services
R771	Preventive Care Services Vaccine Administration
R779	Other preventive services
Obstetric Exams and Screening	
80055	Obstetric profile (with maternity dx)
81000-81002	Urinalysis (with maternity dx)
83540	Iron (with maternity dx)
85007, 85009	Differential WBC count (with maternity dx)
85025, 85027	Automated hemogram (with maternity dx)
86762	Antibody, rubella (with maternity dx)
86850	Transfusion screen (with maternity dx)
86900-86901	Blood typing (with maternity dx)
87086, 87088	Urine culture/colony count; urine bacteria (with maternity dx)
87340-87341	Hepatitis B surface antigen detection (with maternity dx)
87350	Hepatitis B antigen (HBeAg) (with maternity dx)
Newborn	
84030	Phenylalanine (PKU)
84443	Thyroid stimulating hormone (TSH)

*According to the American Cancer Society, individuals who are at an average risk for colorectal cancer should be tested at age 50 years and older. Individuals who are at an increased or high risk for colorectal cancer should be tested before age 50 years and more often. Colonoscopies are covered for average-risk members age 50 years and older and for high-risk members based on current national guidelines.

ADDENDUM C

Medicaid and the State Children's Health Insurance Program (SCHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or SCHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or SCHIP and you live in a State listed below, you can contact your State Medicaid or SCHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or SCHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or SCHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

<table>
<tr><th>ALABAMA – Medicaid</th><th>CALIFORNIA – Medicaid</th></tr>
<tr><td>Website: http://www.medicaid.alabama.gov

Phone: 1-800-362-1504</td><td>Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 1-866-298-8443</td></tr>
<tr><th>ALASKA – Medicaid</th><th>COLORADO – Medicaid and CHIP</th></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529</td><td rowspan="3">Medicaid Website: http://www.colorado.gov/

Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

CHIP Website: http:// www.CHPplus.org

CHIP Phone: 303-866-3243</td></tr>
<tr><th>ARIZONA – CHIP</th></tr>
<tr><td>Website: http://www.azahcccs.gov/applicants/default.aspx

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td></tr>
</table>

ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid	**MISSOURI** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/ clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	
MASSACHUSETTS – Medicaid and CHIP	**NEW MEXICO –** Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	
NEW YORK – Medicaid	**TEXAS** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH** – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	**VERMONT**– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

OKLAHOMA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	**WISCONSIN** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565