HEART OF ILLINOIS EDUCATORS ASSOCIATION
HEALTH BENEFIT PLAN
THIRD AMENDMENT

This Third Amendment to the Heart of Illinois Educators Association Health Benefit Plan ("Plan") is made in duplicate at Washington, Illinois, on the date noted below, by the Heart of Illinois Educators Association ("Employer").

WHEREAS, the Plan grants the Employer the right to amend the provisions of the Plan, and

WHEREAS, the Employer desires to make such amendments;

NOW, THEREFORE, the Plan is hereby amended as follows, effective July 1, 2014;

1. The Schedule of Benefits is hereby amended as follows:

    - The Essential Health Benefits Maximum is hereby deleted in its entirety.
    - The Supplemental Accident Benefit, and any reference thereto, is hereby deleted in its entirety. The Supplemental Accident Benefit will now be paid the same as any other illness.

2. The following provision as stated in the Deductible provision of the Schedule of Benefits (and any other applicable reference in the Plan) is hereby deleted:

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

    The following is substituted therefore:

    - The Preferred and Non-Preferred Provider deductibles do not cross-accumulate.

3. The following provision as stated in the Out-of-Pocket provision of the Schedule of Benefits (and any other applicable reference in the Plan) is hereby deleted:

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

    The following is substituted therefore:

    - The Preferred and Non-Preferred Provider out-of-pockets do not cross accumulate.

4. The "Copayment bullet" as shown under the Maximum Out-of-Pocket provision of the Schedule of Benefits (and any other applicable reference in the Plan) is hereby modified as follows:

   - Copayments (except to the extent required by the Affordable Care Act)

5. The Kidney Dialysis provision of the Schedule of Benefits is hereby deleted in its entirety and replaced with the following:

	Preferred Provider and Out-of-Area[1]	**Non-Preferred Provider**
Dialysis Treatment	100% of the rate negotiated by EthiCare Advisors, Inc., if applicable. If no negotiated rate is applicable, 100% of the Reasonable and Customary charges for Reasonable claims, after all applicable deductibles and coinsurance.	

6. The Utilization Review provision in the Schedule of Benefits is hereby deleted and substituted with the following:

   The Utilization Review Administrator, AIMM, must be notified prior to any of the services listed below. Call at least 72 hours prior to an elective service, procedure, or admission and no later than 72 hours after an emergency service, procedure, or admission. In the case of pregnancy, please contact AIMM as soon as your pregnancy is confirmed:

   All hospitalizations
   PET, MRI and CT Scans
   Transplants (including evaluation)
   Inpatient Rehabilitation Facility Stays
   All Substance Abuse Treatment
   Skilled Nursing Facility Stays
   Home Health Care
   Hospice Care
   Dialysis*
   Speech, Occupational and Physical Therapy
   Cardiac Rehabilitation Therapy
   Outpatient Surgery
   All Mental Disorder Treatment
   Chemotherapy and Radiation Therapy
   Durable Medical Equipment Costing over $500
   Pre-natal and Maternity Care

   *Dialysis services require pre-certification through AIMM and Ethicare. Please call Ethicare at (877) 218-4955.

   Call AIMM at (877) 217-7695 for pre-certification of the above benefits. Pre-certification is the member's responsibility, and failure to obtain pre-certification may result in a reduction of benefits.

7. The Prescription Drug Benefits provision in the Schedule of Benefits is hereby deleted and replaced with the following:

	Retail (Up to a 90 day supply)	**Mail Order (60 – 90 day supply)**
Generic Drug	30 Day Supply: $7 60 Day Supply: $14	$14

	90 Day Supply: $21	
Preferred Brand Drug	30 Day Supply: 20% with $50 maximum 60 Day Supply: 20% with $100 maximum 90 Day Supply: 20% with a $150 maximum	20% with a $100 maximum
Non-Preferred Brand Drug	30 Day Supply: 20% with $75 maximum 60 Day Supply: 20% with $150 maximum 90 Day Supply: 20% with $225 maximum	20% with $150 maximum
Specialty Drugs	30 Day Supply: $75	

The portion of the drug cost that the Covered Person or Covered Dependent is responsible to pay, is listed above. **Please note that if the patient insists on a brand name medication when there is a generic available and the Physician's prescription allows for a generic to be dispensed, a penalty will be added to the applicable copayment.** This penalty is the difference in price between the brand name medication and its available generic. Copayment expenses do not apply to the deductible or out-of-pocket maximums except to the extent required under the Affordable Care Act.

NOTE: Proton Pump Inhibitors and Antidiabetic Classification of drugs are now part of LDI's Step Therapy Program.

8. The Basic Services co-insurance and the Orthodontic Services Lifetime Maximum in the Dental Benefits provision of the Schedule of Benefits are hereby modified as follows:

Basic Services	Deductible, then 80%
Orthodontic Services Lifetime Maximum	$1,000 per person

9. The Vision Benefits provision of the Schedule of Benefits is deleted in its entirety and replaced with the following:

VISION BENEFITS

Benefit	Maximum
Eye Examination, Frames, Lenses and/or Contact Lenses	$200 maximum benefit payable per 24 month period

NOTE: There is not a Preferred Provider Network for routine vision benefits stated above.

10. Any reference in the Plan Document to a pre-existing condition limitation or exclusion is hereby removed in its entirety. This Plan no longer limits or excludes pre-existing conditions incurred on and after the effective date of this amendment.

11. The Utilization Review provision of the "Benefits" section is hereby deleted and substituted with the following:

The Utilization Review Administrator, AIMM, must be notified prior to any of the services listed below. Call at least 72 hours prior to an elective service, procedure, or admission and no later than 72 hours after an emergency service, procedure, or admission. In the case of pregnancy, please contact AIMM as soon as your pregnancy is confirmed:

All hospitalizations	Dialysis*
PET, MRI and CT Scans	Speech, Occupational and Physical Therapy
Transplants (including evaluation)	Cardiac Rehabilitation Therapy
Inpatient Rehabilitation Facility Stays	Outpatient Surgery
All Substance Abuse Treatment	All Mental Disorder Treatment
Skilled Nursing Facility Stays	Chemotherapy and Radiation Therapy
Home Health Care	Durable Medical Equipment Costing over $500
Hospice Care	Pre-natal and Maternity Care

*Dialysis services require pre-certification through AIMM and Ethicare. Please call Ethicare at (877) 218-4955.

Call AIMM at (877) 217-7695 for pre-certification of the above benefits. Pre-certification is the member's responsibility, and failure to obtain pre-certification may result in a reduction of benefits.

Upon notification, the Utilization Review Administrator will review the:

- Medical Necessity for the services being rendered;
- Appropriateness of the place of treatment for the Sickness or Injury;
- Duration of the treatment; and
- Extension, if necessary, of a previously reviewed treatment plan.

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 described herein, shall be further reduced by the lesser of (i) any eligible charges, or (ii) the amount described in the Schedule of Benefits.

Individual Case Management

Case Management is conducted by the Utilization Review Administrator to ensure that the course of treatment meets evidence based clinical guidelines and is eligible for benefits under the Plan. These activities are conducted with a focus on patient advocacy in compliance with applicable regulatory requirements. The Covered Person or Covered Dependent and that person's Physician will be requested to cooperate in the Case Management process; failure to do so may reduce or exclude benefits.

Alternative Treatment Options Coordinated by the Case Manager are covered. Once agreement has been reached, the Case Manager will advise the Claims Administrator to reimburse for Medically Necessary expenses as stated in the treatment plan, even if

these expenses normally would not be paid by the Plan. These exceptions to plan design are not establishing precedent. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriated or recommended for any other patient, even one with the same diagnosis.

Pre-Certification is not a guarantee of benefits, eligibility, payment, nor is it a medical treatment decision or advice. The program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other Health Care Provider.

Dialysis Pre-Certification
The Plan has entered into an agreement with EthiCare Advisors, Inc., a specialized cost-management company, to manage Dialysis costs. EthiCare Advisors, Inc. has been retained for the purposes of pre-certification, utilization review and case management applicable to all Dialysis services and/or supplies. EthiCare Advisors, Inc. must be contacted at (877) 218-4955 by the Covered Person's or Covered Dependent's nephrologist and/or the Dialysis treatment clinic before the onset of treatment. If the nephrologist and/or Dialysis treatment clinic has not entered into an agreement with EthiCare Advisors, Inc., payment for all Dialysis services and supplies will be strictly limited to the Reasonable and Customary reimbursement rate as defined by the Plan, and all other Plan Limitations and Exclusions shall apply.

12. The following is added to the Medical Benefits section of the Plan and placed under the Other Covered Services provision:

    Clinical Trials (Routine Patient Costs). Benefits are provided to qualified individuals for the routine patient costs of items and services furnished in connection with participation in an Approved Clinical Trial.

13. Items 1 and 2 of the Vision Benefits Limitations provisions are deleted in their entirety

14. The following is added to and made a part of letter "D" pertaining to Experimental Treatment in the General Limitations section of the Plan Document:

    All phases of clinical trials shall be considered Experimental; however, routine patient costs provided to qualified individuals for items and services furnished in connection with participation in an Approved Clinical Trial will be covered as stated herein.

15. The following definition is added to the Definitions section and placed alphabetically therein:

    Approved Clinical Trial means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new Drug application reviewed by the FDA (if such application is required).

Effective for plan years renewing on and after January 1, 2014, the Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan's Network area unless out-of Network benefits are otherwise provided under the plan.

16. The following is added to the end of number 2 of the Definition of Experimental Treatment in the Definitions section:

    (Note that all phases of clinical trials shall be considered Experimental; however, routine patient costs provided to qualified individuals for items and services furnished in connection with participation in an Approved Clinical Trial will be covered as stated herein);

17. The Your Rights Under ERISA Section is hereby deleted.

The intentions of this Plan are to comply with all applicable rules and regulations of the Patient Protection and Affordable Care Act (PPACA). In the event that any provisions of this Plan contradict any rules and regulations of PPACA, the rules and regulations of PPACA shall apply as of the applicable effective date required by the Plan.

All other provisions of the Plan remain as stated.

HEART OF ILLINOIS EDUCATORS ASSOCIATION

By: _____

Its: President

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