



**HEALTH
CARE
PLAN
DESCRIPTION**

**Effective
January 1, 2007**

ELIGIBILITY

Enrolled full-time employees and enrolled eligible dependents are covered for expenses commencing on and after the employee's first day of employment.

If you do not enroll either yourself or your dependents within seven days after your first day of employment, it will be necessary to await an open enrollment period. However, if you lose other coverage on yourself or dependents due to divorce, death of a spouse or loss of employment, you may apply for single or family coverage within 30 days of such occurrence and have coverage effective the date you complete the enrollment form. You also may add dependent coverage within 30 days from the date you become married with coverage effective on the date of marriage or date you sign the enrollment card, whichever is later. Dependent coverage, if you are unmarried, also may be added at the birth of your first child, providing application is made prior to the birth. If you are married and have single coverage, you may add a first dependent child (not your spouse) provided you apply for coverage prior to the birth.

If you do not change coverage as provided within the period specified, it will be necessary for you to await an open enrollment period, at a date established by the College.

If two (2) employees are married, one employee must be designated as the employee and their spouse and/or child (ren) would be considered dependents.

Those employees who were approved to retire under the guidelines established by the Board of Trustees may elect to continue their coverage. The retiree must reimburse the College for the applicable premium.

A surviving spouse of an active employee may elect to continue within the College's group health plan for six months.

A surviving spouse of a retired employee (who retired under the guidelines established by the Board of Trustees) may elect to continue their coverage.

The surviving spouse would continue to pay the regular employee contribution, or retiree premium, for participating in the Plan.

CONTRIBUTIONS

The Plan Sponsor determines the amount of your contribution. The balance of the costs is paid by the College.

TERMINATION

Coverage terminates at midnight on the day on which your employment terminates, you request termination, you fail to pay required contributions, or you are no longer eligible. Any retroactive terminations must be approved by the Plan Sponsor. You may be eligible to continue coverage under legislation commonly referred to as COBRA. Information is available in the Benefits office.

Coverage for a retiree will terminate in the event he/she fails to pay the cost of his/her premium as required or in the event the retiree is employed elsewhere and eligible for coverage under another group health plan.

Coverage for the surviving spouse of an active employee or of an eligible retiree will terminate in the event the surviving spouse fails to pay the required premium, already is covered by another group health plan, remarries, or becomes eligible for another group health plan.

DEFINITIONS

You and Employee: a regular, full-time employee of Illinois Central College, including qualified retirees, on an approved leave, or disabled as provided in the College's personnel manuals, contracts or service agreements.

Plan: the group health care plan described herein. This is the complete Health Care Plan Description.

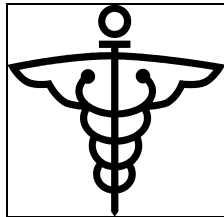
Physician: a duly licensed M.D., D.O., D.D.S., D.C., D.P.M., a Nurse Practitioner under the direction of an M.D.; Physician Assistant under the direction of an M.D., audiologists, or in the instance of out-patient psychotherapy, a clinical psychologist, or an LCSW/MSW/LCPC designation if services are obtained through a tax-supported regional mental health center or under the direction of an M.D.

Dependent: your lawful spouse and unmarried natural child(ren) under age 19 (or under age 25 if a full-time student) and primarily dependent upon you for support. Twelve credit hours per semester concurrent enrollment at one or more colleges will constitute full-time student status. Otherwise eligible dependents who are students completing a regular academic term will not be terminated due to age prior to the following September 1 (February 1 for Spring) if they have applied for and either have been accepted for or pre-registered for full-time student status for the forthcoming regular academic term, excluding summer session, provided they have not reached their 25th birthday and are otherwise eligible as dependents.

Child: also includes a step-child or other child for whom you have assumed legal responsibility when such child resides primarily in your household in a normal parent-child relationship. Legal documentation will be required.

Hospital: an institution primarily engaged in providing care for the sick under supervision of physicians and registered nurses on a 24-hour basis. Non-hospital substance abuse treatment facilities are eligible providers when approved by the Claim Administrator, and that the maximum covered expenses for substance abuse treatment will be the prevailing ConsumerCare charges for such services. It does not include health resorts, rest homes and nursing homes.

Reasonable and Customary: The fee most commonly charged in a geographical area by other physicians and healthcare providers for the same service under comparable circumstances, as determined by the Claims Administrator.



COMPREHENSIVE MEDICAL BENEFITS

Medical Benefits are payable at the listed amounts after satisfying a \$250 deductible per person (\$500 per family) for expenses incurred in a calendar year to a lifetime limit of \$3,000,000. Reasonable and customary charges apply.

The \$250 deductible will be applied to all health benefits with the exception of dental, vision, prescription drugs, and the wellness benefits.

The out-of-pocket limit, excluding the deductible, is \$1,000 per person (\$2,000 per family) per calendar year. This limit, however, does not apply to dental or vision benefits, prescription drug co-pays, to employee wellness benefits, to expenses payable at 50%, to amounts which are over reasonable and customary, or to other non-covered expenses.

Payable at 100%*

Reasonable and customary physician fees and hospital charges are payable in full, subject to the calendar year deductible, for the following:

Out-patient Surgery whenever rendered when you are not a hospital bed patient overnight.

Out-patient Diagnostic Tests when related to a specific condition or medical complaint.

Out-patient Accident Initial Care within 72 hours following an accident and follow-up out-patient care within 90 days of an accident.

Out-patient Medical Emergency Care in non-accident cases, for the sudden onset of a condition which would result in permanent medical consequences in the absence of immediate medical attention.

Examples: loss of respiration, heart attack, profuse nose bleed, food poisoning, acute bronchitis attack, and convulsions.

*Examples of conditions **not** considered medical emergencies: upper respiratory infection, urinary tract infection, and temperature less than 102.*

Payable at 90%*

After a \$250 deductible per person (\$500 per family) for expenses incurred in a calendar year, the Plan will pay 90% of reasonable and customary charges, subject to the limitations and exclusions specified, to a lifetime maximum of \$3,000,000, for the following:

1. Hospital room and board charges up to a hospital's most common semi-private rate; full charges for intensive care, coronary care or special care units; and in-patient or out-patient miscellaneous services and supplies provided by a hospital when necessary to treat a condition of illness or injury. Admissions extending beyond 23 hours will be treated as in-patient services.
2. Physician fees for office calls and other professional services. When multiple surgical procedures are performed, the reasonable and customary allowance will be adjusted.
3. Routine exams, immunizations/vaccinations, and school physicals would be covered for reasonable and customary charges for children through the age of 18.
4. Physical or occupational therapy when performed by a registered physical or occupational therapist (or licensed therapist assistant or certified occupational therapy assistant working under the direction of a registered physical or occupational therapist).
5. Charges of a licensed speech therapist to restore speech loss due to an injury, stroke or surgery.
6. In-hospital insulin and drugs and medicines prescribed by a physician. TPN or other medically necessary intravenous or injectable drug therapy, but only from a vendor approved by the Plan on a case by case basis, if the cost of the medication exceeds \$500 per month.
7. Leg, arm, neck and back braces or services of a registered physical therapist (or licensed physical therapist assistant working under the direction of a registered physical therapist) only when prescribed by a physician.
8. Professional ambulance service when medically necessary to transport a patient to the nearest hospital where required medical treatment can be provided. Ambulance service is provided from a hospital to a nursing home or to the individual's home when approved by the Claims Administrator.

9. Durable medical equipment rental, or purchase thereof at the option of the Claim Administrator, when prescribed by a physician and where such rental equipment is not used customarily except for medical purposes.
10. Hospice, home health care, or services of private duty nurse when such individual normally does not reside in the patient's home, if prescribed by a physician and if pre-approved by the Claim Administrator.
11. Artificial limbs and other prosthetic applications for accidents or illnesses incurred while covered under this Plan or the program it replaced.
12. Oxygen, blood and related administration charges.
13. Surgical and related supplies which are primarily only for medical purposes.
14. Hearing aids and batteries with a maximum \$1,000 limit per person per year with 50% coverage for batteries.

*** 50% for hospital and related physician fees when care is received in Peoria County at other than the Methodist Medical Center if (1) the care is available at Methodist, or (2) any additional time required to transport the patient to Methodist would not jeopardize the patient's health, or (3) an exception is not made by the Plan due to extenuating circumstances. This provision does not apply to care received outside of Peoria County or to those Plan participants who select the Freedom of Choice option.**

Mental Health and Substance Abuse Treatment Benefits

Employee Assistance Program (EAP): Immediate confidential assistance is available for health plan participants through the College EAP provider. The initial consultation and three (3) follow-up visits are at no charge to the employee or family members. When further services are needed, referrals to covered providers can be made.

Covered Providers: All outpatient psychotherapy services must be performed by a psychiatrist (MD) or by a clinical psychologist. Services may also be performed by a licensed clinical social worker (LCSW) or a master's prepared social worker (MSW) ONLY if it is under the direction of a psychiatrist or if services are obtained through a tax supported regional mental health center.

Payable at 90%

Inpatient mental health care with a limit of \$30,000 per year and \$60,000 per lifetime not to exceed 60 days per lifetime. The defined deductibles under the plan apply.

Payable at 50%

Outpatient psychotherapy charges up to a maximum of \$1,200 per person per year pursuant to the use of a covered provider as described above. A partial hospitalization program as pre-approved by the claim administrator is considered outpatient care and is subject to the same provisions as outpatient psychotherapy coverage. The defined deductibles under the plan apply.

Substance Abuse Treatment

Covered Providers: Substance abuse treatment facilities must be approved by the Claim Administrator. The maximum covered expenses for substance abuse treatment will be the prevailing ConsumerCare charges for such services. It does not include health resorts, rest homes or nursing homes.

Coverage: Inpatient and outpatient treatment for substance abuse is subject to the plan deductible and is then covered under the same provisions and restrictions as mental health care. The treatment must take place at a facility approved by the Claim Administrator as described above. The coverage limit for inpatient substance abuse treatment is \$30,000 per year and \$60,000 per lifetime not to exceed 60 days per lifetime. The coverage limit for outpatient substance abuse treatment is \$1,200 per person per year.

Cross coverage: Treatment specifically for substance abuse is not defined as mental health care under the plan and therefore those benefits are not directly applied to the coverage limits for mental health care.

WELLNESS BENEFITS

The following exams and lab tests are payable once per calendar year, up to the benefit amount specified:

		<u>Eff. 1/1/07</u>	<u>Eff. 1/1/08</u>
<i>Routine Mammogram and reading</i>	<i>to \$95</i>	<i>\$125</i>	<i>\$155</i>
<i>PSA and Digital Exam</i>	<i>to \$80</i>	<i>\$80</i>	<i>\$80</i>
<i>Pap Lab work, Exam and reading</i>	<i>to \$80</i>	<i>\$80</i>	<i>\$80</i>
<i>Health Screening Physical</i>	<i>to \$50</i>	<i>\$50</i>	<i>\$50</i>



DENTAL BENEFITS

Deductible does not apply

The Plan will pay reasonable and customary fees of licensed dentists up to a maximum of \$1,200 per calendar year per person on the following basis:

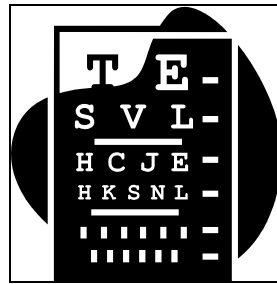
Payable at 80%

1. Oral exams, prophylaxis (cleaning and polishing), and bitewing x-rays twice per calendar year (January 1 – December 31)
2. Full mouth x-rays once in any consecutive 24-month period.
3. Emergency treatment.
4. Topical fluoride applications (to age19)
5. Endodontics, including pulpotomy, pulp capping and root canal therapy.
6. Denture repair and relining, and re-cementing of inlays, on-lays and crowns.
7. Extractions, dental tests, oral surgery and related anesthesia.
8. Fillings consisting of amalgam, silicate and plastic restorations, and sealants.
9. Space maintainers.
10. Periodontics (diseases of the gum) and apicoectomy.

Payable at 50%

1. Gold foil restorations, inlays and on-lays, and crowns and crown buildup.
2. Dentures, full and partial.
3. Bridges, fixed and removable.
4. Orthodontics (to age 19).

The date you take possession of a dental appliance will be the date the expense is incurred. The Plan will **not** pay for lost or misplaced dentures, cosmetic dentistry, implants or bridges involving dental implants; the placement of crowns, inlays and on-lays, bridges and dentures or the relining of dentures more than once per consecutive five-year period for the same tooth or teeth; general anesthesia for three or less simple extractions; hospital charges for out-patient surgery for the removal of impacted teeth, unless pre-approved by the Claim Administrator, or charges of a dentist except as set forth above.



VISION CARE BENEFITS

Examinations

Deductible does not apply

80% of reasonable and customary charges for one exam per individual in any calendar year (January 1 – December 31)

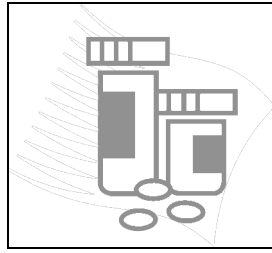
Frames, Lenses and Contact Lenses

\$125 maximum per individual once in any calendar year (January 1 – December 31)

NOTE: Dates for examinations and for dispensing frames and lenses may differ. Benefits are once per calendar year. The date you take possession of frames, lenses or contact lenses will be the date the expense is incurred.

CONSUMERCARE PROGRAM

The Consumercare directory lists health care professionals who have agreed to accept Mutual Medical's determination of reasonable and customary charges. You pay only the applicable deductible and co-insurance if you receive covered services from an active provider in the directory.



PRESCRIPTION DRUG BENEFITS

Most prescriptions are payable at 100% subject to the co-pay amount for each prescription or refill. You pay the co-pay directly to the pharmacy at the time of the purchase.

The maximum medication payable under this program for any one prescription or refill, including insulin, is a 90-day supply. The 90-day supply may be obtained through the mail-order only. Information regarding mail-order is available online at www.medco.com or in the Benefits office.

The maximum supply allowed at a pharmacy (non-mail order) is a 30-day supply.

For a 30-day prescription, 23 days must pass before the prescription can be refilled. For a 90-day prescription, 76 days must pass before a refill may be obtained.

Drugs covered under the Plan must be for the purpose of treating an underlying cause of an illness or injury by relieving pain or preventing serious medical consequences.

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order, is not covered by this program.

If you do obtain a prescription from a pharmacy or physician who does not participate in this program, it will be necessary for you to pay the entire charge for the prescription and to file a Direct Reimbursement Claim form (available in the Benefits Office). You must complete the form and include a receipt from your pharmacy or doctor that contains all required information and mail it to the address shown on the back of the form. Your reimbursement will be mailed to you and will be based on the dollar amount called for under this program.

The Prescription Drug Program does **not** cover drugs not approved by the FDA, experimental drugs, fertility drugs, drugs for sexual dysfunction, dietary drugs or drugs for weight reduction, hair loss, growth hormones, injectable medications (except insulin) unless preauthorized by the Plan, drugs prescribed primarily for cosmetic purposes, or drugs which may be dispensed without a prescription.

Also excluded is medication which is to be taken by or administered, in whole or in part, to an individual while a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

OPTIONAL HEALTH PLANS

The College offers three additional medical plans that can provide greater total coverage for active employees and their dependents. Individuals covered by another health care plan may elect either option 2, 3 or 4 rather than the regular Medical Benefits. Immediately if other coverage is lost, or at your option each January 1, you may change to regular Medical Benefits with the same Single or Family coverage you had under option 2 or 3. An individual covered under option 4 may change to regular Medical Benefits at any time. An individual may not be covered under both regular Medical Benefits and option 2, 3, or 4, or under the Wrap-around plan through more than one employer. Except for the Maxi Plan, you may not be covered under a different option than your dependents without approval of the Plan Sponsor. Reasonable and customary determinations apply to each option. If the contractual benefits of your other health care plan, when combined with the Wrap-around or Supplemental Plans, are ever less than total benefits that would have been received under regular Medical Benefits, the Wrap-around or Supplemental Plans will pay the difference as a No Loss benefit.

2. **WRAP-AROUND PLAN**

If your other group health coverage has a deductible, the Wrap-around plan increases total benefits by largely eliminating deductibles and co-insurance under the ICC plan. Wrap-around can better pay deductibles and co-insurance you may have under your spousal or other health care plan. Benefits are (no deductible), 100% of the first \$500 then 20% up to a maximum per person of \$1,500 per year on the same scope of benefits provided under the regular Medical Plan. In addition, routine exams and related test and immunizations and vaccinations, and the co-pays under your spouse's drug plan are covered in full. If you do not have a drug card through your spouse, you will continue to have the ICC drug card, but the co-pays in this case will not be reimbursed.

3. **SUPPLEMENTAL PLAN**

The Supplemental Plan pays 100% (no deductible) for physician office visits related to an illness or injury, routine exams and related tests, immunizations, vaccinations, and allergy injections and the co-pays not paid by your spouse's drug plan. If you do not have a drug card through your spouse, you will continue to have the ICC drug card, but the co-pays in this case will not be reimbursed.

4. **MAXI PLAN**

The Maxi Plan covers the same scope of benefits as the regular Medical Benefits. Benefits are 100%, no deductible, except that the maximum paid on an inpatient hospital bill is \$1,500 per admission. In addition, the Maxi Plan pays routine exams and related tests and immunizations and vaccinations in full as well as the co-pays under the ICC drug plan. An individual may change from the Maxi Plan to the Comprehensive Medical Benefits at any time. This plan is not available to retirees.

LIMITATIONS AND EXCLUSIONS

This Health Care Plan will **not** pay for:

1. Charges exceeding reasonable and customary, as determined by the Claim Administrator, including fees of national network providers.
2. Benefits beyond \$500 during the first 12 months of coverage for any condition existing on an individual's effective date of coverage in the Plan. This does not apply to a newborn covered by the Plan from date of birth.
3. Expenses not related to a condition of illness or injury.
4. Expenses related to a non-covered service.
5. Expenses not specifically included within this Plan Description as benefits of the Plan.
6. Hospital charges or related physician fees during inpatient admissions primarily for care which could be performed safely on an out-patient basis.
7. Non-surgical in-patient hospital admission for back pain.
8. Hospital or facility charges for out-patient surgery for a vasectomy or for the removal of benign moles/nevi/lesions or for other services which are performed normally on an out-patient basis in a physician's office.
9. Non-accident use of a hospital emergency room in the absence of a condition which would result in permanent medical consequences in the absence of immediate medical attention.
10. Hospital admissions commencing or other services received before an individual's effective date of coverage in the Plan, or after termination from the Plan. If covered by another group health care plan, coverage for existing in-patient admissions also will terminate at the time your coverage terminates under this Plan.
11. Physician in-patient charges for a well newborn.
12. Steroid or post-operative epidurals in lieu of conventional oral and injectable medications.
13. Personal comfort items such as television rental, barber services, special meals or guest meals.
14. Routine physical exams, school medical exams, physicals for athletics, immunizations, and vaccinations except as provided under item 3 of Benefits Payable at 90% or under the Wellness Benefits.
15. Physical or occupational therapy when not performed by a registered physical or occupational therapist (or licensed physical therapist assistant or certified occupational therapy assistant working under the direction of a registered physical or occupational therapist).

16. Charges for a nurse/nurse practitioner except when under the direction of an MD.
17. Charges for a physician's assistant except when under the direction of an MD.
18. Job-related injuries or diseases covered by or pending under Workers Compensation or similar legislation.
19. Expenses in federal or state institutions except tax- supported regional mental health centers.
20. Expenses payable by Medicare, or which would have been payable by Medicare had the person properly enrolled in Medicare or applied for Social Security Disability benefits in order to qualify for Medicare in the event the person is disabled (does not apply where contrary to federal law). Disabled individuals must apply for Social Security Disability benefits the later of 9/1/2004 or within six (6) months after the date of disability.
21. Expenses in connection with custodial care, education or training, or for which you or the patient are not liable for payment in the absence of health care plan coverage.
22. Injury or illness due to war or act of war or while serving in the armed forces.
23. Cosmetic surgery unless necessary to correct traumatic injuries incurred while covered under the Plan or the program it replaced or to correct any congenital deformities evidenced in infancy.
24. Expenses related to mastectomy in the absence of a malignancy or expenses related to breast reduction or enlargement other than post-mastectomy reconstructive surgery following a covered mastectomy, dependent daughter pregnancy, sex changes, penile implants, infertility, growth hormone therapy, artificial insemination, or reverse sterilization procedures. (Sterilization procedures performed after at least one full year of eligible employment are covered).
25. Hearing aids and the tests for the fitting thereof, or other charges for services performed by an audiologist beyond the maximum benefit of the Plan.
26. Routine foot care such as trimming nails and callouses.
27. Expenses related to bariatric surgery or weight reduction or expenses related to nutrition counseling or nicotine addiction.
28. Expenses related to radial keratotomy or other surgical procedures to correct nearsightedness, farsightedness or similar conditions.
29. Orthotics.
30. Mandibular or maxillary (jaw) surgery except for fracture repair.
31. Treatment for temporomandibular joint dysfunction (TMJ).
32. Vision care expenses not included under Vision Care Benefits unless related to cataract surgery or non-refractive diseases of the eye.

33. The “facility fee” billed by a physician’s office or licensed surgery center when the provider does not have an agreement with the Plan or the claim administrator.
34. Telephone calls.
35. Customized wheelchairs.
36. Travel expenses.
37. Expenses denied by another health care plan or HMO for lack of pre-treatment approval, improper claim filing procedures or lack of additional physician opinions.
38. Services which do not meet accepted medical standards or are considered investigational, experimental, or not medically necessary under Medicare criteria.
39. Expenses covered by auto, property and casualty or liability insurance or for which another party or organization is liable for payment. Upon completion of the Plan’s reimbursement agreement, these expenses may be paid at the option of the Claim Administrator on an interim basis while the settlement with such other insurance, party or organization is pending.

CLAIM PROCEDURES

Medical: Always present (or be prepared to present) your Illinois Central College Health Care Plan ID Card when receiving covered services because the Card contains billing directions for your hospital or doctor. Hospitals and doctors should send their standard forms directly to Mutual Medical Plans at the address shown on your ID Card. Miscellaneous covered expenses may be submitted by you directly to Mutual Medical Plans along with a completed Medical Claim form available in the Benefits Office.

Dental and Vision: Obtain a Dental or Vision Service Report form from the Benefits Office; complete the employee portion; then have the dentist or doctor complete the balance of the form and send it directly to Mutual Medical Plans at the address shown on the form.

Benefits normally will be paid directly to the provider of the service unless the claim indicates the bill already has been paid; however, the Plan reserves the right to pay you, or a relative in the event of your death. Benefits are not assignable.

Claims must be filed within 180 days after the end of the calendar year in which the expense is incurred.

The Plan reserves subrogation rights and the right to recover any overpayment from you or any person or organization. If payments which should have been made by the Plan are made by another health care program, the Plan shall have the right to pay over to such organization or party making such payments any amount it shall determine is warranted to satisfy this provision, and the Plan shall be discharged fully from liability.

COORDINATION OF BENEFITS

If you or a dependent have any other health insurance or health care plan coverage, benefits will be coordinated so that no more than 100% of covered charges will be paid or reimbursed.

Your spouse's coverage will be primary on him or her. In the case of a dependent child, the parent whose birthday falls earliest in the calendar year will be considered primary. In the case of children with divorced parents, in the absence of court-determined responsibility, the parent with custody will be primary. Any coordination of benefits issue which is not addressed herein or within the Plan's other provisions will be settled using the NAIC guidelines adopted by the State of Illinois.

If you have other health care plan coverage as the subscriber or as a survivor, it will be primary.

Notwithstanding any other provisions herein, this Plan will be secondary to any coverage, including individual medical policies not purchased through payroll deduction with the Plan sponsor, which does not have coordination of benefits provision.

This Plan is secondary, excess and supplemental to any student insurance coverage which may be in effect.

CLAIM APPEALS PROCESS

An appeal may be made by an employee enrolled in this Plan when there is an alleged misinterpretation or misapplication of the specific benefits provided by this Plan that cannot be resolved satisfactorily through regular claim channels.

Questions and complaints regarding the initial settlement of an insurance claim should be directed verbally or in writing to the Claim Administrator (Mutual Medical Plans, Inc.).

After a claim has been denied by the Claim Administrator, an appeal may be sent to the Risk Management and Benefits Director at the College. The appeal must be submitted within the number of days specified, must be in writing and must be accompanied by copies of itemized bills and benefit explanation worksheets on which claims were denied. Reasons must be provided for why you feel the claim should be paid under applicable provisions of this Health Care Plan Description. A decision will be sent to you within 60 days after a full appeal is received.

A six-member Insurance Appeal Advisory Committee shall be designated to review complaints regarding claim denials and to recommend disposition of disputed claims.

Copies of the procedure and form for submitting appeals to the Committee are available in the Benefits Office.

The Plan Sponsor's decision on an appeal shall be final and not subject to litigation.

PLAN SPONSOR/AGENT FOR LEGAL PROCESS

Illinois Central College
One College Drive
East Peoria, IL 61635-0001

ATTN: Vice President for Administration and Finance
(309) 694-5477

TYPE ADMINISTRATION

Third-party Administration--Claim Administrator

Mutual Medical Plans, Inc.
PO Box 689
Peoria, IL 61652
(309) 674-0888

AMENDMENTS

The Plan Sponsor reserves the right to amend or to discontinue the Plan.

LEGISLATION

Where provisions of the Plan conflict with applicable state or federal law, present or future, such legislation shall prevail.

PRIVACY STATEMENT

The Claims Administrator may release to, or obtain from any party, without consent of or notice to any person, any information the Plan Administrator or Claims Administrator deems necessary to carry out the provisions of the Plan. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the Plan Administrator or Claims Administrator may only use or disclose such information when related to treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

Only individuals, and their clerical support staff, who are involved with Plan administration, supervision or management, shall be given protected health information, and only to the extent necessary to perform duties assigned by the Plan Administrator. 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; (c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (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 available 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.