Health Alliance™

2010 Standardized Medicare Supplement Group Policy

Health Alliance Medical Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance Medical Plans does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance Medical Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance Medical Plans, Customer Service, 3310 Fields South Drive, Champaign, IL 61822, telephone: 1-800-965-4022, TTY: 711, fax: 217-365-7494, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For Language Access Services:

English:
If you, or someone you're helping, has questions about Health Alliance Medical Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-965-4022.

Spanish:
ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame 1-800-965-4022 (TTY: 711).

Chinese:
注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫1-800-965-4022（TTY：711）。

Polish:
UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. Zadzwoń 1-800-965-4022 (TTY: 711).

Vietnamese:
Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-800-965-4022 (TTY: 711).

Korean:
주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다.
1-800-965-4022 전화 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. Вызов 1-800-965-4022 (TTY: 711).

Tagalog:
Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag 1-800-965-4022 (TTY: 711).

Arabic:
تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . ستدعاء 1-800-965-4022 (TTY: 711).

German:
Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. Anruf 1-800-965-4022 (TTY: 711).

French:
ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez 1-800-965-4022 (TTY: 711).

Gujarati:
ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કૉલ 1-800-965-4022 (TTY: 711).

Japanese:
注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。
1-800-965-4022コール（TTY: 711）。

Pennsylvania Dutch:
LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. Bel 1-800-965-4022 (TTY: 711).

Ukrainian:
УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. Виклик 1-800-965-4022 (TTY: 711).

Italian:
ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare 1-800-965-4022 (TTY: 711).

3310 Fields South Drive
Champaign, Illinois 61822
1-877-933-0028 • TTY 711
www.healthalliance.org

2010 STANDARDIZED MEDICARE SUPPLEMENT GROUP POLICY

GUARANTEED RENEWABLE
This policy is guaranteed renewable for life by the timely payment of the premium at the rate in effect on each premium due date. Premiums will automatically increase at certain ages. We reserve the right to change the table of premium rates. Premium rates for all policies of this form in force in your state of residence may be changed. See Part VI, Premiums, on page 6.

This is a legal contract. **Please read it carefully.**

CONSIDERATION
The policy is dated and takes effect on the effective date shown on the Policy Schedule. All periods of insurance will begin and end at midnight, standard time, at the place you are currently living.

NOTICE TO BUYER
This policy may not cover all of your medical expenses.

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PART I. DEFINITIONS

- **Benefit Period**—the period as determined by Medicare which begins on the date you are first confined in a Hospital. It ends following a period of 60 days during which you have not been confined in a Hospital or Skilled Nursing Facility.
- **Calendar Year**—the period of time beginning on January 1 and ending on December 31 of the same year.
- **Creditable Coverage**—the coverage you had prior to application with no break in coverage greater than 63 days. Creditable Coverage includes: a group health plan; health insurance coverage; Medicare; Medicaid; TRICARE/CHAMPUS; a medical program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under the Federal Employees Health Benefits Program; a public health plan; or a health benefit plan of the Peace Corps.
- **Duplication of Insurance**—a proposed new accident and health insurance policy that would provide some of the benefits or coverage you already have under an existing accident and health insurance policy.
- **Eligible Individual**—those individuals who, within 63 days prior to application, were covered by: Medicare Advantage, a Medicare Select plan, a Medicare Risk or Cost plan, a Medicare HMO, a Medicare Supplement policy or an employee welfare benefits plan that supplemented the benefits under Medicare. Plan F is only available to individuals who are Medicare eligible prior to 01/01/2020.
- **Group Health Plan**—a plan (including a self-insured plan) offered, or contributed to, by an employer (including a self-employed person) or employee organization to provide health care, directly or otherwise, to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.
- **Health Alliance Medical Plans, Inc. (Health Alliance)**—an Illinois domestic stock insurance company, herein referred to as we, us and our.
- **Health Care Expenses**—expenses of a nonprofit health, Hospital or medical service corporation, prepaid health plan or similar organization associated with the delivery of health care services in which providers of the health care services are reimbursed for such services on an other than fee-for-service basis which are similar to incurred losses of insurers. Such expenses shall not include: home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes capital costs, administrative casts and claims processing costs.
- **Hospital**—a Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged that primarily provides custodial care, including training in routines of daily living.

- **Injury**—accidental bodily injury, independent of disease or bodily infirmity that occurs while the insurance is in force.
- **Lifetime Inpatient Reserve Days**—a total of 60 extra days in the Hospital provided to you by Medicare. These reserve days must be used if you are hospitalized for more than 90 days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days you have left.
- **Medicare**—Title 1 Part 1 of Public Law 89-97, Federal Medicare Act of 1965, as amended. The federal health insurance program for people 65 years of age or older, certain younger people with disabilities and people with Lou Gehrig's disease or End Stage Renal Disease (generally those with permanent kidney failure who need dialysis).
- **Medicare Eligible Expenses**—expenses of the kinds covered by Medicare Parts A & B, to the extent recognized as reasonable and medically necessary by Medicare.
- **Member**—the person eligible for benefits and listed on the Policy Schedule as insured, herein referred to as you and your.
- **Open Enrollment**—the six-month period beginning with the first day of the month in which an individual is both 65 years of age or older and enrolled for benefits under Medicare Part B.
- **Over-Insurance**— duplication of insurance to the extent that the combination of existing insurance and proposed insurance would substantially exceed any loss reasonably expected to be incurred.
- **Physician**—a person licensed to practice medicine in all its branches in the state where services are rendered.
- **Policy Schedule**—a document specifying the name of the individual insured under the policy, the policy number, the effective date of coverage, the initial premium amount and any other information we may choose to provide.
- **Pre-Existing Condition**—a condition for which medical advice was given or treatment was recommended by or received from a Physician within six months before the effective date of coverage.
- **Sickness**—illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.
- **Skilled Nursing Facility**—a facility (or distinct part of a facility) which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

PART II. BENEFITS PROVIDED BY THIS POLICY

Effective date of coverage: The benefits of this policy begin on the effective date shown on the Policy Schedule. We will pay benefits as indicated in the Policy Schedule if this policy is in force at the time the covered expense is incurred. If a Member is not entitled to Part A or Part B of Medicare, we will pay benefits as if he or she were entitled to both parts.

Please refer to your Policy Schedule for the specific benefits provided by this policy.

PART III. PRE-EXISTING CONDITION LIMITATIONS

We will NOT pay for: any expenses incurred for care or treatment of a Pre-Existing Condition for the first six months from the effective date of coverage. This exclusion does not apply if you qualify as an Eligible Individual, if you apply for this policy during your Open Enrollment period and have at least six months of

Creditable Coverage, or if this policy is replacing another Medicare Supplement policy and a six-month waiting period has already been satisfied.

If you had less than six months prior Creditable Coverage, the Pre-Existing Condition limitation will be reduced by the amount of Creditable Coverage available. If this policy is replacing another Medicare supplement policy, credit will be given for any portion of the waiting period that has been satisfied.

PART IV. POLICY EXCLUSIONS

We will NOT pay for:

- Any expense a Member incurs before the effective date of coverage;
- Any loss that is covered by workers' compensation or employers' liability laws;
- Custodial care;
- Any expense a Member incurs which Medicare does not consider to be a covered charge or approved charge unless such benefits are expressly provided for by this policy;
- Home health care to the extent not covered by Medicare; or
- Benefits covered by Medicare or employer or union-based group health plans.

PART V. MEDICARE BENEFIT AMOUNT CHANGES

The benefits under this policy will change automatically to coincide with any changes in the applicable Medicare deductible amount and coinsurance. Premiums may be modified to correspond with such changes. When this happens, we will notify you no less than 30 days prior to the date the changes take effect, and we will provide you with the necessary changes to this policy.

PART VI. PREMIUMS

Payment for health care services covered by this policy must be made as follows: you or anyone paying on your behalf, for example your Group, must remit the specified premium to Health Alliance monthly. You are entitled to the benefits of this policy only if Health Alliance receives the full amount of the premium within the required time period.

Premiums will automatically increase when the Member enters a new age bracket. These age brackets are specified in the Policy Schedule.

The premium rate is subject to change annually on the first premium due date in a Calendar Year to correspond with annual changes in the Medicare program. Health Alliance reserves the right to change the premium rate at any other time for all policies of this form. Written notice will be provided to the Group not less than 30 days prior to the effective date of the change.

PART VII. ELIGIBILITY, SUSPENSION AND TERMINATION

Eligibility: Persons eligible for this policy include individuals over the age of 65 and disabled persons under age 65 on Medicare Part B.

Suspension of coverage by you when entitled to Medicaid or covered under a Group Health Plan: By written notice to us, you may request that your benefits and premiums under this policy be suspended for the period in which you applied for and were determined to be entitled to Medicaid or covered under an employer or union-based Group Health Plan. Medicaid is defined as medical assistance under Title XIX of the Social Security Act.

We must receive written notification within 90 days after the date you become entitled to Medicaid or covered under an employer or union-based Group Health Plan. Upon receipt of timely written notice, we will return to you that portion of your premium paid for the suspension period minus paid claims, or you will be billed the difference. The suspension period shall not exceed 24 months.

If Medicaid entitlement or Group Health Plan coverage ends, your benefits and premiums under this policy shall be automatically reinstated as of the date entitlement ended. You must send written notice of the loss of such entitlement or coverage to us within 90 days after the date of such loss. You must also pay the premium due from the date such entitlement or coverage ended.

Reinstated coverage will have: (1) No waiting period for treatment of Pre-Existing Conditions; (2) basically the same coverage that was in effect before the suspension date; and (3) premiums on terms at least as favorable to you as the premium terms you would have had if your coverage had not been suspended.

Termination: Coverage may be terminated for intentional material misrepresentation.

In the event the Group terminates this policy, all rights to benefits and services will cease on the effective day of termination. The Group will be responsible for notifying you of termination of this policy and your right to elect coverage under an individual plan or another group plan.

If you terminate employment with your Group, coverage under this policy will terminate the last day of the month in which employment ends or as otherwise specified in the Group Enrollment Agreement. If you become ineligible for continued membership in the Group while the Group Enrollment Agreement between Health Alliance and the Group is in effect, you may be eligible to enroll in an individual plan offered by Health Alliance.

In the event that Health Alliance terminates this policy, all rights to benefits and services will cease on the effective day of termination. Health Alliance will be responsible for notifying you of termination of this policy and your right to elect coverage under an individual plan offered by Health Alliance or another group plan offered by your employer.

PART VIII. GENERAL PROVISIONS

Clerical error: Clerical error by Health Alliance in quoting benefits or in processing or maintaining any record pertaining to the coverage under this policy will not invalidate coverage otherwise validly in force or reinstate coverage otherwise validly terminated.

Confidentiality of medical records: Information from medical records and information received by Physicians will be kept confidential and will not be disclosed unless Health Alliance receives prior written consent from you.

Conformity with state statutes: Any provision of this policy, which on its effective date is in conflict with the laws of the state where you live, is amended to conform to the minimum requirement of those laws.

Entire contract changes: This policy and any attachments are the entire contract of insurance. No change in this policy will be valid unless approved in writing by an executive officer of Health Alliance. No agent has the authority to change this contract or to waive any of its provisions. Any provision, term, benefit or condition of coverage in this policy may be amended, revised or deleted by Health Alliance in accordance with changes in state and/or federal law. This may be done without your consent.

Grace period: A grace period of 31 days will be granted for the payment of each premium except the initial premium. If you or anyone paying on your behalf fails to pay the premium within 31 days of the due date, this policy is automatically cancelled, and you will not be entitled to further benefits. You will remain liable for any applicable share of the premium for the time coverage was in effect, as well as for any deductible amounts owed because of services received during the grace period.

Legal action: No legal action shall be brought to recover on this policy before 60 days after written proof of loss has been furnished. No legal action shall be brought to recover on this policy more than three years after the time written proof of loss was furnished.

Member identification card: The member identification card issued to you upon enrollment in this policy is for identification only. Possession of a Health Alliance member identification card does not give the holder any right to services or other benefits under this policy. To be entitled to such services or benefits, the holder of the card must be a Member on whose behalf all applicable premiums under this policy have actually been paid. Any person receiving services or other benefits to which he or she is not entitled under this policy will be charged the usual, customary and reasonable fee, in addition to any other remedies available to Health Alliance as set forth in this policy.

Misstatement of age: If your age has been misstated, we may collect or refund the difference in premiums from the effective date of your coverage, based on the correct age. If this information is learned while a claim is pending under this policy, we may deduct any premiums due us from the claim payment.

Notice of claim: Any claim or bill for covered health services must be submitted within 60 days of the service or as soon thereafter as reasonably possible. Notice given by you or on your behalf should be sent to:

Claims Department
Health Alliance Medical Plans, Inc.
3310 Fields South Drive
Champaign, Illinois 61822

Health Alliance is not responsible for claims or bills submitted more than one year after the provision or initiation of the service to which the claim or bill relates.

Notices: Any notice given under the terms of this policy by Health Alliance to a Member will be:

- in writing;
- addressed to the Member at the address shown on the Policy Schedule, unless notice of change of address has been given by the Member in the manner described below; and
- put into effect by deposit in any United States Post Office.

Any notice to be given under the terms of this policy by a Member to Health Alliance will be:

- in writing;
- addressed to Health Alliance Medical Plans, Inc., 3310 Fields South Drive, Champaign, Illinois 61822; and
- put into effect by deposit in any United States Post Office.

All notices given in this manner will be deemed to have been received by the party to whom addressed five business days after deposit in said post office.

Our right to examine Hospital and medical records: In the event of a claim, we retain the right to examine your Hospital charts and medical records at our expense if we find it necessary.

Payment of claims: All benefits under this policy will be paid to the provider unless you request in writing, prior to filing proof of such loss, that we pay benefits directly to you.

At our option, unless we receive prior written instruction from you, any health care benefits unpaid at your death will be paid to one of the following: (1) To the health care provider rendering the service for which benefits are due or (2) to your estate.

If benefits payable are $1,000 or less, we may pay someone related to you by blood or marriage whom we consider to be entitled to the benefits. We will be relieved of further obligation as to this benefit payment when made by us in good faith.

Physical examination: We have the right, at our expense, to request that you have a physical examination performed by a Physician when and as often as it may be reasonably required while a claim is pending or open.

Pro rata refund: If we receive written request and proof of death, we will refund to your estate any premium you have paid which covers the period following the end of the month after which we receive the notice.

Proof of loss: Written proof to support any claim must be furnished to us at our home office within 180 days after the date of the loss. Failure to provide written proof will not invalidate or reduce any claim if it was not reasonably possible to send such proof within the time allowed. In no event, except in the absence of legal capacity, will any claim be accepted later than one year from the time proof is required.

Reinstatement: If the policy lapses, we will require an application and sufficient premium for reinstatement. This policy will be reinstated on the 45th day following the date of the reinstatement application if we do not notify you in writing of our approval or disapproval prior to the 45th day.

The reinstated policy will cover only loss resulting from an Injury sustained after the date of reinstatement or a Sickness first manifested more than 10 days after the date of reinstatement. In all other respects, your rights and our rights under the policy will be the same as they were immediately before the due date of the unpaid premium, subject to any restrictions attached in connection with the reinstatements.

State medical assistance program: Benefits are normally payable to providers. There may be cases when you are entitled to benefits under Medicaid or a similar state medical assistance program. In such cases, we will pay the benefits due under this policy to that state's department charged with administering the above program. If payment is made prior to being notified of such entitlement, we will be discharged to the extent of any such payment made by us in good faith.

Time of payment of claims: All benefits due will be paid upon receipt of proof of loss. We will notify you within 30 days if additional information is needed. If payment is delayed more than 30 days after all necessary information regarding the claim has been received, we will pay interest on benefits due.

Time limit on certain defenses: No misstatements made in the application for this policy will be used to void this contract or to deny a claim for loss incurred after two years from the effective date of coverage. This provision does not include fraudulent misstatements.

Other provisions: Health Alliance is not liable, in any event, for any act or omission of the professional personnel of any medical group, hospital or other provider of services to Members.

The health care coverage provided for in this policy is not transferable to another party by any Member.