



Limited Medical Program for:

PTLFC-AAUP-AFT

Basic Medical Plan w/\$100 Wellness Benefit

REAL BENEFITS. REAL VALUE!

Guaranteed Issue

Maternity Included From Day One

HIPAA Compliant

"A" Rated Carrier

Assignable Benefits

PPO Discounts

\$100 Wellness Benefit Included

Vision Discount Program

\$10,000 Accidental Death Benefit

COBRA Administration

| Summary of Benefits (Use of network providers is NOT required) | In Network BeechStreet PPO | Outside Network |
|--|--|--|
| Office Visit Benefit (No Deductible!) | \$20 Co-pay \$65 per visit maximum benefit | \$35 Co-pay \$65 per visit maximum benefit |
| Rx Benefit (For Name Brands and Generics) <i>\$750 annual max</i> | Covered at 50% | |
| CatalystRx is a "Discount Pharmacy Card". By showing your card at the pharmacy, you receive CatalystRx point-of-service discounts averaging 18%. Then turn in your claim to HCH Administration for a 50% reimbursement of the amount you paid up to \$750 annual max. <i>(Accepted at all major Pharmacies across U.S.- Walgreen's, Wal-Mart, Eckerd, Rite Aid, etc.)</i> | | |
| Maximum Benefit Per Accident or Sickness <i>For each separate Accident or Sickness/ Per covered person.</i> | \$2,500 (per occurrence) | |
| Deductible Per Accident or Sickness | \$200 | |
| Hospital Care <i>Inpatient and Out patient</i> | Covered at 60% | Covered at 50% |
| Physician Services <i>Including Chiropractic Services</i> | Covered at 60% | Covered at 50% |
| Additional In-Patient Benefit <i>(pays after per Accident or Sickness maximum benefit is used)</i> | \$400 per day <i>(30 days max per calendar year)</i> | |
| Lab/ X-Ray/ Diagnostic Care <i>(Including Interpretation)</i> | Covered at 60% up to \$750 per occurrence | Covered at 50% up to \$750 per occurrence |
| Also Included, Discount Lab Program... <ul style="list-style-type: none"> • Unlimited Lab Tests at savings of up to 70%. Utilizing these facilities: Quest Diagnostics and Lab Corp | | |
| Emergency Room/ Ambulance <i>*After \$350 ER Deductible (Deductible waived if admitted into a hospital or if due to an accident)</i> | Covered at 60% | |
| Surgery (In patient or Out patient) | Covered at 60% | Covered at 50% |
| Other Covered Medical Services <i>Home Health Care Skilled Nursing Facility Hospice Care Physical Therapy Durable Medical Equipment</i> | Covered at 60% | Covered at 50% |

All State Mandated Benefits Included!

If a condition is treated in the prior six months, there will be no coverage for that pre-existing condition for 12 months. Credit will be given with proof of prior coverage.

All benefits are limited to UCR Charges at the 80th percentile based on data provided by Medical Data Research (MDR).

PTLFC-AAUP-AFT Monthly Rate Effective September 1, 2009
Monthly Rates include a \$10.00 per Month Billing Fee

| Single | Two Party | Family |
|-----------------|-----------------|-----------------|
| \$116.55 | \$208.50 | \$300.50 |

Underwritten By:



Aegis Group
 American Sentinel Insurance Company
 Aegis Security Insurance Company
 A.M. Best Rating: A (Excellent)

Administered by HCH, Inc.,
 Peoria, IL. 800-322-1516



Traditional Medical Plan w/\$100 Wellness Benefit

REAL BENEFITS. REAL VALUE!

Guaranteed Issue

Maternity Included From Day One

HIPAA Compliant

"A" Rated Carrier

Assignable Benefits

PPO Discounts


\$100 Wellness Benefit Included

Vision Discount Program

\$10,000 Accidental Death Benefit

COBRA Administration

Underwritten By:



Aegis Group
 American Sentinel Insurance Company
 Aegis Security Insurance Company
 A.M. Best Rating: A (Excellent)

| Summary of Benefits <small>(Use of network providers is NOT required)</small> | In Network BeechStreet PPO | Outside Network |
|--|---|--|
| Office Visit Benefit (No Deductible!) | \$15 Co-pay \$75 per visit maximum benefit | \$25 Co-pay \$75 per visit maximum benefit |
| Rx Benefit (For Name Brands and Generics) <i>\$1,000 annual max</i> | Covered at 50% | |
| <small>CatalystRx is a "Discount Pharmacy Card". By showing your card at the pharmacy, you receive CatalystRx point-of-service discounts averaging 18%. Then turn in your claim to HCH Administration for a 50% reimbursement of the amount you paid up to \$1,000 annual max. (Accepted at all major Pharmacies across U.S.- Walgreen's, Wal-Mart, Eckerd, Rite Aid, etc.)</small> | | |
| Maximum Benefit Per Accident or Sickness <small>For each separate Accident or Sickness/ Per covered person.</small> | \$3,500 (per occurrence) | |
| Deductible Per Accident or Sickness | \$150 | |
| Hospital Care <small>Inpatient and Out patient</small> | Covered at 70% | Covered at 60% |
| Physician Services <small>Including Chiropractic Services</small> | Covered at 70% | Covered at 60% |
| Additional In-Patient Benefit <small>(pays after per Accident or Sickness maximum benefit is used)</small> | \$500 per day (30 days max per calendar year) | |
| Lab/ X-Ray/ Diagnostic Care <small>(Including Interpretation)</small> | Covered at 70% up to \$1,000 per occurrence | Covered at 60% up to \$1,000 per occurrence |
| <small>Also Included, Discount Lab Program...</small> <ul style="list-style-type: none"> • Unlimited Lab Tests at savings of up to 70%. <small>Utilizing these facilities: Quest Diagnostics and Lab Corp</small> | | |
| Emergency Room/ Ambulance <small>*After \$350 ER Deductible (Deductible waived if admitted into a hospital or if due to an accident)</small> | Covered at 70% | |
| Surgery (In patient or Out patient) | Covered at 70% | Covered at 60% |
| Other Covered Medical Services <small>Home Health Care Skilled Nursing Facility Hospice Care Physical Therapy Durable Medical Equipment</small> | Covered at 60% | Covered at 50% |

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Administered by HCH, Inc.,
Peoria, IL. 800-322-1516

| PTLFC-AAUP-AFT Monthly Rate Effective September 1, 2009 | | |
|--|-----------------|-----------------|
| Monthly Rates include a \$10.00 per Month Billing Fee | | |
| Single | Two Party | Family |
| \$145.50 | \$266.50 | \$387.50 |

Enrollment Question Please Call 1-800-692-7338



Enhanced Medical Plan w/\$100 Wellness Benefit

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Guaranteed Issue

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HIPAA Compliant

"A" Rated Carrier

Assignable Benefits

PPO Discounts

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\$10,000 Accidental Death Benefit

COBRA Administration

Underwritten By:

Aegis Group

Aegis Group
American Sentinel Insurance Company
Aegis Security Insurance Company
A.M. Best Rating: A (Excellent)

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| Maximum Benefit Per Accident or Sickness <i>For each separate Accident or Sickness/ Per covered person.</i> | \$5,000 (per occurrence) | |
| Deductible Per Accident or Sickness | \$150 | |
| Hospital Care <i>Inpatient and Out patient</i> | Covered at 80% | Covered at 70% |
| Physician Services <i>Including Chiropractic Services</i> | Covered at 80% | Covered at 70% |
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PTLFC-AAUP-AFT Monthly Rate Effective September 1, 2009

Monthly Rates include a \$10.00 per Month Billing Fee

| Single | Two Party | Family |
|-----------------|-----------------|-----------------|
| \$177.50 | \$334.50 | \$489.50 |

Administered by HCH, Inc.,
Peoria, IL 800-322-1516

Enrollment Questions Please call 1-800-692-7338



AEGIS SECURITY INSURANCE COMPANY
Enrollment/Change Request

Group Information - To be completed by Union
 Group Name _____ Group Number _____ Plan _____
 PTLFC-AAUP-AFT PT-NJ7044 Enhanced/Traditional/Basic

A. Type of Activity - To Be Completed by Union. Refer to instructions on back before completing this form. Print clearly.

1. Enrollment of New Enrollee/Subscriber

| | | | |
|----------------|----------------|------------------|----------------|
| Effective Date | ____/____/____ | Date of Contract | ____/____/____ |
|----------------|----------------|------------------|----------------|

2. Change - Check all that apply

| | | |
|--|----------------|--------|
| <input type="checkbox"/> Add Spouse | Date of Event | Reason |
| <input type="checkbox"/> Add Dependent Child | ____/____/____ | _____ |
| <input type="checkbox"/> Name Change | ____/____/____ | _____ |
| <input type="checkbox"/> Change Plan | ____/____/____ | _____ |
| <input type="checkbox"/> Other | ____/____/____ | _____ |

3. Remove or Terminate - Check all that apply

| | | |
|---|----------------|--------|
| <input type="checkbox"/> Remove Spouse * | Effective Date | Reason |
| <input type="checkbox"/> Remove Dependent Child * | ____/____/____ | _____ |
| <input type="checkbox"/> Enrollee/Subscriber Withdrawal/Termination | ____/____/____ | _____ |

NOTE: Enrollee/Subscriber must be enrolled for spouse/dependent(s) to have coverage.
 * Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Union for available options.
 Coverage for Enrollee/Subscriber Dependents
 Length of Continuation: 12 mos 18 mos 29 mos 36 mos total disability*
 Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____
 * Attach proof of total disability

B. Enrollee/Subscriber Information - Complete Sections B-H

Last name, First name, M.I. _____
 Social Security Number _____ Home Telephone (____) _____
 Home address _____ Apt. No. _____ City, State _____ Zip Code _____
 Employer Name _____ Work Telephone (____) _____
 Work Address _____ City, State _____ Zip Code _____
 Date of Employment: _____ Hours worked per week: _____

C. Plan Option – Your selection must be offered by the Union
 Check one: Traditional Basic Value
 Enhanced

D. Individuals Covered – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student.

| Enrollee/Subscriber | (A)dd (C)hange (R)emove | Last Name, First Name, M.I. | Sex M F | Birthdate MM/DD/YYYY | Social Security Number | Other Health Coverage | Previous Coverage Check if Yes |
|---------------------|-------------------------------|--------------------------------|------------|-------------------------|---------------------------|-----------------------------|--------------------------------------|
| Spouse | | | | | | | |
| Child | | | | | | | |
| Child | | | | | | | |
| Child | | | | | | | |
| Child | | | | | | | |
| Child | | | | | | | |

E. Pre-Existing Conditions Statement

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate response to the following questions. Carriers can only use the information to expedite the processing of claims.

1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following?
 Yes No
 If "Yes," check appropriate box(es) below.

- a. Alcoholism or Drug Abuse
- b. Arthritis
- c. Blood Disorder
- d. Back or Neck Disorder, Injury or Pain
- e. Cancer or Tumors
- f. Diabetes
- g. Gastro or intestinal Disorder
- h. Heart Disorder or Condition or Chest Pain
- i. High Blood Pressure
- j. Kidney or Liver Disorder
- k. Lung or Respiratory Disorder
- l. Mental or Nervous Disorder
- m. Paralysis, Stroke or Epilepsy

2. During the past 6 months, have you or any dependent to be covered:
 Yes No
 a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as above stated?

b. been advised to have treatment or surgery or testing that has not been done?
 c. been admitted to a hospital or other health care facility as an inpatient?
 d. taken prescribed medication?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Other/Previous Insurance

Is your spouse employed? Yes No If "Yes" give name and address of your spouse's employer

If "Yes" to Other Health Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID #.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

G. Dependent Information

Does any dependent listed in Section D live at a different address than the Enrollee/Subscriber? Yes No If "Yes" who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

H. Union Member Signature *If you have questions concerning the benefits and services provided by or excluded under this Plan contact a Customer Service Representative before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the enrollee/subscriber's copy of this enrollment/change request. I authorize deductions for any required contributions.

Enrollee/Subscriber Signature – Required X _____ Date ____ / ____ / ____ E-mail Address _____

I. Union Verification – To be Completed by Union

Union Signature – Required X _____ Title _____ Date ____ / ____ / ____

Enrollee/Subscriber copy may be used as a temporary ID card for 30 days from the effective date if authorized by Union.

NJ-ECR

**Instructions
Union**

- Complete the Union Group Information in the upper right corner of the form.
- Section A – Type of Activity: Check boxes indicating reason(s) for submitting application
- Complete Section I – Union Verification in the lower right corner of the form.
 - Union must complete this section for all new enrollments, coverage changes and terminations.
 - Union must sign and date the Enrollment/Change Request in order for it to be processed.

Enrollee/Subscriber – Complete Sections B-H

Section B – Enrollee/Subscriber Information:

- Complete all information in order for your application to be processed.

Section C – Plan Option:

- Check one Plan Option box.
- Select only an option offered by the Union.

Section D – Individuals Covered:

- Add/Change/Remove – Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you must attach a current course schedule or letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and begin continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health coverage, check off the “Yes” box(es) and Complete Section F – Other/Previous Insurance.

Section E – Pre-Existing Conditions Statement:

- Complete this section for all new enrollment or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section G – Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section H – Enrollee/Subscriber Signature:

- Complete this section for all new enrollments, coverage changes and terminations.

- Enrollee/Subscriber must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I – Union Verification:

- Union must complete this section for all new enrollments, coverage changes and terminations.
- Union must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Enrollee/Subscriber Acknowledgement and Agreements

On behalf of myself and the dependents listed on the reverse side I agree to or with the following:

1. a) I authorize the sources stated below to give to Aegis Security Insurance Company, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Aegis Security Insurance Company has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c) I know that I have a right to receive a copy of the authorization if I request one.
d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Aegis Security Insurance Company plan, coverage is provided by Aegis Security Insurance Company in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Aegis Security Insurance Company.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.



Attn: Accounting Dept
209 W. RB Garrett Ave
Peoria IL 61605
1-800-322-1516

ACKNOWLEDGEMENT AND AUTHORIZATION AGREEMENT FOR AUTOMATIC DIRECT DEBITS (ACH Debits)

I hereby authorize HCH Administration, Inc. to initiate debit (ACH) entries to the below named account for payment of health insurance premiums. The charge will be initiated on the 2nd day of the billing period. I also authorize any adjustment (debit or credit) if necessary, to the account for debits initiated in error.

Please Print
All Items Must Be Completed

Union Members Name _____
Union Members Phone Number (____) _____ **Email Address:** _____

Plan Design **Basic:** _____ **Enhanced** _____

Financial Institution Name _____

Financial Institution Address _____
State: _____ Zip: _____

Financial Institution I (____) _____

Routing/Transit (ABA) # _____

Account # _____

Type of Account (Select One) Checking
 Savings

I agree to provide HCH Administration with an unused and voided personal check from this account as verification for the bank account stated above (please attach).

The ACH Debit includes \$10 per billing. You may elect to pay semi-annually to reduce the number of billing charges, i.e. 6 months of premium for one \$10 billing charge. The ACH Debit will be initiated by HCH Administration, Inc. on the 2nd day of each billing period. This authorization will remain in force until written cancellation from me is received by HCH Administration, Inc. If an account has been closed, it is my responsibility to complete a new Authorization Agreement with a valid bank account and immediately submit to HCH Administration, Inc. at the above address.

Payment Cycle: **Monthly** _____ **Semi-Annually** _____

Signature: _____

Date: _____



Attn: Accounting Dept
209 W. RB Garrett Ave
Peoria IL 61605
1-800-322-1516

ACKNOWLEDGEMENT AND AUTHORIZATION AGREEMENT FOR AUTOMATIC CREDIT CARD CHARGE INITIATIONS

I hereby authorize HCH Administration, Inc. to initiate a charge to the below named Credit Card account for payment of monthly health insurance premiums. The charge will be initiated on the 2nd day of each month. I also authorize any adjustment (debit or credit), if necessary, to the account for charges initiated in error.

Please Print

All Items Must Be Completed

Union Members name _____
Union Members phone (____) _____ **Email Address:** _____

Plan Design **Basic:** _____ **Enhanced** _____

Card Holder Name: _____

Mailing Address: _____
State: _____ Zip: _____

Phone: (____) _____

Credit Card Type: Check One Visa MasterCard

Name as it Appears on Card: _____

Account Number: _____

Three digit number on back of card: _____

Expiration Date: _____

The Charge is \$10 per billing. You may elect to pay semi-annually to reduce the number of billing charges, i.e. 6 months of premium for one \$10 billing charge. The Charge will be initiated by HCH Administration, Inc. on the 2nd day of each billing period. **This authorization will remain in force until written cancellation from the cardholder is received by HCH Administration, Inc.** If an account has been closed, it is the Cardholder's responsibility to complete a new Authorization Agreement with a valid credit card account and immediately submit to HCH Administration, Inc. at the above address.

Payment Cycle: **Monthly** _____ **Semi-Annually** _____

Signature: _____

Date: _____

Confidential

AEGIS SECURITY INSURANCE COMPANY EMPLOYEES AND INDEPENDENT CONTRACTORS HEALTH INSURANCE PROGRAM

- Freedom of choice of physicians or hospitals
- Covers inpatient charges, outpatient charges, prescription drugs and durable medical equipment up to the maximum chosen
- Aegis Security Insurance Company doesn't restrict a subscriber on the type of prescription drugs. The subscriber can have name brand or generic drugs at the same reimbursement level.
- Aegis Security will pay up to 70% of MDR (usual and customary) charges
- Aegis Security can turn a clean claim around in one week
- No medical underwriting
- No waiting period, first of the month adds & deletes
- Coverage for Chiropractic services
- The medical maximums per occurrence are renewed every 52 weeks, no limit on the number of occurrences
- Composite rates are available with a census
- Aegis Security Insurance Company will list bill every month
- Aegis Security Insurance Company will administer COBRA
- HIPPA certificates can eliminate the pre-existing clause
- Pregnancy can't have a pre-existing clause

This program is available to employers of 51 or more full time employees (full time means an employee who works more than 25 hours per week). Also, for the purposes of calculating full time employees do not include employees who are covered under a union contract.

In addition, there must be an employer contribution to the premium in order to be an eligible group.

If your client meets these criteria, we can cover all your full time and part time employees and your independent contractors.

A policy cannot be issued unless 5 or more eligible persons subscribe to the coverage.

Agt flyer-NJ (0703)