MEMBERSHIP AND UNDERWRITING GUIDELINES AGREEMENT

EDUCATORS HEALTH ALLIANCE

and

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

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BLUE CROSS AND BLUE SHIELD OF NEBRASKA

This Agreement is entered into by and between **Educators Health Alliance (EHA) and Blue Cross and Blue Shield of Nebraska (BCBSNE)** for the EHAendorsed group health plan, underwritten by BCBSNE, to be effective September 1, 2011. In consideration of mutual promises, the parties agree as follows:

Effective September 1, 1997, provisions of these Guidelines were conformed to be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I. School Group Billing - Eligibility and Participation Requirements.

A. Basic Eligibility Requirements

1. All public school districts and other subgroups with members of the Nebraska State Education Association (NSEA), Nebraska Council of School Administrators (NCSA) or Nebraska Association of School Boards (NASB) and other groups related to Nebraska public education (from pre-school to post-secondary education) shall be eligible to apply for the BCBSNE group health plan. EHA participating groups enrolled as of May 24, 2007 that do not qualify for the above eligibility shall remain eligible as long as they are continuously enrolled in the EHA and meet all other requirements of participation. See Part IX. for requirements for enrolling new school groups (subgroups).

2. Eligible employees and their eligible dependents are eligible to apply for the PPO coverage as outlined in the Master Group Application if they are actively at work on the date coverage takes effect. This "actively at work" provision shall not preclude coverage for persons who are disabled or not at work because of a health condition to the extent required by HIPAA. Professional employees (teachers and administrators) are eligible if they work a full-time equivalency (FTE) of 0.4 per year. Classified employees must work at least 17 1/2 hours per week per nine-month period unless otherwise specified on the School Group Application. School board members are deemed to be employees for purposes of this Agreement with the exception of requirements in Part I.C.

3. Annually, each subgroup will be required to sign a School Group Application furnished by the group health plan verifying they meet the requirements in Part I.C.

4. Subgroups must secure disclaimers from employees who do not enroll for the plan's health benefits at the time of their eligibility. Each disclaimer should be kept in the subgroup's health benefits file. BCBSNE retains the right to audit the health benefits files in order to substantiate the participation levels for the application of Part I.C.

   In addition, in order to be eligible for a Special Enrollment Period, the Employee also must have declined enrollment for coverage in writing when coverage under the plan was last offered, citing other "Creditable Coverage" as the reason for declination. This provision requires the employer to require such a statement and

provide notice and information about the consequences of noncompliance with such requirement. (Also see Special Enrollment Period in Part I.E.).

5. BCBSNE will allow a subgroup to add classified employees and/or their dependents to the billing if this is the first time the subgroup has made a contribution for all members of this class.

6. All employees and their dependents enrolling for PPO coverage will be subject to a 12month Waiting Period for Preexisting Conditions (18 months for Late Enrollees), as stated in the benefit contract, except for persons under age 19 or if specifically waived as stated in these guidelines.

   These Waiting Periods will be reduced by previous Creditable Coverage, as based on the applicable provisions of the HIPAA portability requirements and state law. The employee must meet the "actively at work" requirement of Part I.A.2., and the employer contribution as outlined in Part I.C. must be attained for all members of this class.

7. The subgroup's selected coverage shall be effective on September 1 or within 60 days of receipt by BCBSNE, whichever is later, provided that the School Group Application is accepted by us and payment of charges is made as provided by this Application. Until the School Group Application is received, accepted and processed by BCBSNE, on or before August 1, 2011, the option selected in the prior year shall continue in effect, if that option is still available (see Part VII.A.). However, any new endorsements or changes made for an available option will also be included, and the rates will be adjusted to the current rates for that option. To facilitate an effective date of the first day of the next month, the School Group Application must be received by BCBSNE by the 15th day of the current month. The Application should not be sent until there has been agreement between the local bargaining unit and the subgroup concerning the health insurance for the bargaining unit members.

8. Spouses and dependents who are added when the subgroup increases its contribution will not be considered late enrollees if a subgroup has an agreement with its employees that the subgroup will increase its contribution after a certain length of employment and the increased contribution is at least one half of the premium for each rate tier.

   In addition, if a subgroup agrees to increase the contribution to its employees, BCBSNE will review the request to waive the late enrollee provision.

9. The EHA program must be exclusive at the subgroup level and will not co-exist with other competing health benefit plans that are not endorsed by EHA.

10. When two or more schools combine into one operating entity, current employees of the pre-combination schools shall be allowed to enroll as new employees pursuant to Part I.E.1. These employees shall not be considered late enrollees nor shall waiting periods for pre-existing conditions apply.

In school mergers where benefit eligibility for the combined entity commences at a later date than the merger date, employees shall have 31 days from that same later date to enroll. Under these circumstances, employees would not be considered late enrollees or have waiting periods for pre-existing conditions.

11. Coverage and premium rates will be in the following four tiers:

a. Employee only
b. Employee plus child(ren)
c. Employee plus spouse
d. Employee plus spouse and child(ren)

B. Subgroup Definition and Creation

1. A Subgroup is a group of employees within a single district or eligible employer that have similar characteristics. The characteristic defining the subgroup must consist of at least one of the following:

   a. Certificated versus Non-Certificated status
   b. Salaried status (Exempt versus Non-exempt)
   c. Employees covered under a single negotiated contract
   d. Other employment groupings, as approved by the BCBSNE Group Underwriting Department

2. Each subgroup within a single district or employer must be based on a difference in employee status or other employment definition that is NOT based on number of hours worked or number or years employed (exception, all part time employees may be grouped into a single subgroup).

3. Each subgroup under EHA will receive a separate monthly billing for premium.

4. New subgroups are subject to approval of the BCBSNE Group Underwriting Department.

5. Subgroups established prior to September 1, 2008 will be allowed to continue subject to all other underwriting guidelines.

C. Participation and Contribution

The following will apply to all EHA subgroups:

1. Net Enrollment Percentage Rule: Any EHA subgroup that has less than 75% enrollment, (excluding those covered under a spouse's plan), shall remain eligible under the EHA and be subject to a 5% premium rate surcharge.

2. Gross Enrollment Percentage Rule: Any EHA subgroup that has less than 50% enrollment, (excluding only those covered by EHA under a spouse's plan), shall remain eligible under the EHA and be subject to a 5% premium rate surcharge.

3. 100% Contribution Rule: Any EHA subgroup where the employer contribution is made exclusively for health insurance premiums only, with no options, and such contribution is in the amount of 100% of the single and 100% of the family rates shall be subject to a 5% premium rate reduction.

   In the case of subgroups offering coverage to part time employees, the 100% may be prorated according to the full-time equivalency (FTE) of the part time employees. For example, a 3/4 time employee (0.75 FTE) would qualify for the 100% with an employer contribution of at least 75% of the full premium toward all rate tiers.

4. The subgroup determinations in items 1. through 3. above shall be applied at the subgroup level. This means there may be multiple subgroups individually measured for the population of a single employer.

5. The rate determinations made from items 1. through 3. above shall be applied cumulatively.

D. Late Enrollees

A late enrollee is an employee or dependent of an employee whose enrollment form is not received within 31 days of his or her initial eligibility or during a Special Enrollment Period. A late enrollee is subject to an 18 month waiting period for Pre-existing Conditions (except for persons under age 19), during which no benefit payment is made for services related to Pre-existing Conditions. This period shall be reduced by periods of prior Creditable Coverage if the Creditable Coverage ended not more than 63 days before the first day of coverage or the first day of the Eligibility Waiting Period, if any. Creditable Coverage will be based on the applicable provisions of HIPAA.

1. Late enrollment is allowed for those employees of subgroups with 50 or fewer eligible employees only at an annual enrollment period as designated for the group health plan.

   No late enrollment will be allowed for employees of subgroups with 51 or more eligible employees.

2. An employee or his or her eligible dependent(s) is not considered a Late Enrollee if:

   a. The individual was covered under other Creditable Coverage at the time of his or her initial eligibility for this group coverage; and

   b. He or she lost coverage under Creditable Coverage as a result of:

      i. Termination of employment;
      ii. Termination of eligibility;
      iii. Involuntary termination of the Creditable Coverage;
      iv. Death of a spouse;
      v. Divorce of a spouse; and

   c. Enrollment was requested within 31 days after termination of the Creditable Coverage; or

d. A court has ordered coverage be provided for a spouse or dependent under the employee's coverage and the request for enrollment is made within 31 days after issuance of the order.

E. Special Enrollment Period

An eligible employee and his or her eligible dependents who have not previously enrolled for coverage may be able to enroll during a 31-day Special Enrollment Period. This coverage is available only to:

1. The eligible employee and/or dependents who declined EHA coverage at the time enrollment was previously offered because they were covered under another group health plan or other health insurance coverage and subsequently lost that coverage because:-

   a. The other coverage was COBRA continuation coverage which now has been exhausted; or

   b. The other coverage was not COBRA continuation coverage, and has been terminated as a result of a loss of eligibility. For this purpose, a loss of eligibility does not result from a voluntary termination of coverage, a failure to pay premiums or reasons determined to be "for cause."

      A loss of eligibility includes a loss due to moving out of the service area of an HMO, or loss due to the exhaustion of a lifetime limit on all benefits.

   c. The other coverage was not COBRA continuation coverage and the employer ceased to make contributions for the other coverage; or

   The employee must have declined enrollment for coverage in writing when this coverage was last offered, citing the other coverage as the reason for declination. This provision requires the Group Applicant required such a statement and provided notice and information about the consequences of non-compliance with such requirement (see Part I.A.4).

2. A person who becomes an eligible dependent through birth, adoption, placement for adoption or marriage. An eligible employee or spouse who has not previously enrolled may also enroll with the new dependent at this time.-

A Special Enrollment Period of 60 days is available to an employee or his or her eligible dependents who are eligible but not enrolled, under either of the following conditions:

1. The employee or dependent is covered under Medicaid of a State Child Health Insurance program (SCHIP), and such coverage is terminated as a result of loss of eligibility.

2. The employee or dependent becomes eligible for premium assistance under Medicaid or a State Child Health Insurance Program (SCHIP) with respect to coverage under the EHA group health plan.

The employee must request enrollment no later than 60 days after the termination of coverage described in paragraph a., or no later than 60 days after the date the employee

or dependent is determined eligible for premium assistance as described in paragraph b. The employee must also enroll (if not already enrolled) in order to enroll his or her eligible dependents at this time.

F. Effective Dates

1. New employees may enroll within the first 31 days from the date of employment. New employee's coverage will be effective on the first of the month following any applicable probationary period set forth in the Application, unless otherwise requested by the employer on the School Group Application. The employer must commence and provide contribution as of the date the employee's coverage is effective.

2. Coverage for all transferees shall be consecutive, i.e., normally commencing the first of the month following the end of the month paid for by the previous employer.

3. Coverage will be considered terminated on the final day of the month in which the employee was considered actively at work, as described in Part I.A.2.

G. Dual Option Plans (Employee Choice)

Requirements applicable to Dual Option Plans are as follows:

1. All subgroups participating in the dual option offering must have at least 10 eligible employees.

2. Subgroups that elect to offer one of the dual option plans must maintain the dual option arrangement for a minimum of three (3) consecutive contract years.

3. Subgroups that elect to offer the $1,500 deductible plan under the dual option arrangement will not qualify for the 5% premium rate reduction associated with the 100% Contribution Rule in Part I.C.3. above.

4. Subgroups that elect to offer the $2,850 deductible HSA eligible plan under the dual option arrangement and contribute 100% of the premium savings to the member's health savings account, will qualify for the 5% premium rate reduction associated with the 100% Contribution Rule in Part I.C.3. above.

5. Temporary Grandfathering of Subgroups: Subgroups that offer a dual option, and as of May 1, 2010 have dual choice through the offering of a PPO plan in conjunction with the $1,250 deductible HSA eligible plan and further are receiving the 5% premium rate reduction, shall have their eligibility to receive the 5% rate reduction temporarily continued provided all other conditions of eligibility for the 5% rate reduction are met. This continued eligibility for the rate reduction will expire on August 31, 2013.

6. Special Enrollment: When a subgroup initially offers one of the dual option plans, this will trigger a Special Enrollment opportunity for the subgroups' employees and their eligible dependents. The employee will have 31 days prior to the effective date of the coverage to enroll in the group health/dental plan. Employees enrolling in the plan will be considered Late Enrollees and will be subject to an 18 month

waiting period for Pre-existing Conditions. A Certificate of Creditable Coverage can reduce or eliminate the waiting period.

7. Employees will be permitted to select one of the available plan options once a year and must maintain their enrollment in the selected plan for a minimum of one (1) year or until the next enrollment period, except as provided in 7. below.

8. Employees who have a HIPAA qualifying event (Birth, Death, Marriage, Divorce, Adoption or Placement for Adoption, or the Loss of Creditable Coverage) will have 31 days from the date of the qualifying event to change the option they have previously enrolled in.

H. Partial Self Funding

The benefit plans available through the EHA program should not be offered as a way for EHA subgroups to partially self fund the deductible, i.e., offering the employee a lower deductible and then having the employer self insure up to the actual deductible. The rates for all of EHA's benefit plans have been set based on the utilization for that particular plan's deductible. The rate would not be adequate under a partially self funded scenario. Those EHA subgroups that are currently partially self funding the deductible may continue to do so without penalty, but effective September 1, 2011, those subgroups that move to this type of arrangement will not be eligible for the 5% premium rate reduction as outlined in Part I.C.3.

II. Direct Bill Plan for Employed Persons

A. Guidelines

Eligible employed persons may join the Direct Bill Program under the circumstances listed below. All persons on Direct Bill must have PPO coverage. Participants will pay their own premiums and will be billed directly at their home address on a monthly basis. All persons must be either an active or special services member of NSEA, NCSA or NASB to be eligible for the Direct Bill Plan.

B. Eligible Persons

Persons eligible to join the Direct Bill Plan include substitute teachers, employees of subgroups who have fewer than ten FTE employees, or a classification of employees whose coverage was terminated to effect an increase in participation percentages**. (Also see paragraphs below, for restrictions.)**

New employees of subgroups of ten FTE teachers or fewer were eligible to join the Direct Bill Plan within 31 days without Waiting Periods for Pre-existing Conditions through August 31, 1998. **Employees not effective on or before September 1, 1998 are not eligible for the Direct Bill Plan. Those grandfathered employees must continue to be employed by a subgroup with 10 FTE or fewer teachers to remain eligible for the Direct Bill Plan.** Upon retirement between ages 50 through 64, the grandfathered employees with dependent coverage may apply for continued dependent coverage in any one of the coverage and rate tiers including dependent coverage.

Substitute teachers. **Substitute teachers who were not subscribers on the Direct Bill Plan on or before September 1, 1998 are not eligible for the Direct Bill Plan. Those grandfathered substitute teachers must continue to meet eligibility requirements to remain on the Direct Bill Plan.**

Termination of Coverage to Effect Increase in Participation. If a subgroup excludes a certain classification of previously eligible employees, in order to increase its participation percentage, those employees are eligible for the Direct Bill Plan. If a subgroup once again includes the classified staff, those staff members are no longer eligible for the Direct Bill Plan and they will be included on the subgroup's plan. Upon retirement between ages 50 through 64, the grandfathered employees with dependent coverage may apply for continued dependent coverage in any one of the coverage and rate tiers including dependent coverage.

III. Continuation of Coverage

Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent amendments provide that upon termination of coverage because of certain qualifying events, employers must allow employees and their dependents to continue their present group health and/or dental plan for 18, 29, or 36 months, depending upon the event. These persons who are eligible for continuation coverage are "qualified beneficiaries." A qualified beneficiary also includes a child born to, or placed for adoption with the covered person during the period of COBRA coverage. Such children have all of the statutory protections and rights of other qualified beneficiaries. **COBRA coverage is subject to fulfillment of conditions and requirements which are the responsibility of the employer and employee.**

Qualifying events include: termination of employment or reduction in hours, death of an employee, divorce or legal separation from employee, employee Medicare entitlement or loss of dependent status.

Conversion coverage may be available pursuant to the terms of the benefit contract.

IV. Continuation of Coverage under Direct Bill Plan after COBRA Coverage is Exhausted

Former members and employees, disabled employees, widows/widowers and dependents of deceased employees, who were enrolled in BCBSNE coverage will be eligible to continue plan coverage under PPO coverage only through the Direct Bill Program. Persons eligible for COBRA continuation coverage must complete 18, 29, or 36 months of COBRA continuation coverage as set forth below. Employees or dependents not eligible for COBRA but otherwise eligible for the Direct Bill Program may enroll in Direct Bill without enrolling in COBRA. As is true with COBRA coverage, the employee will pay his or her own premium without any contribution by the employer. All persons must become a member of the NSEA, NCSA or NASB Special Services if they have coverage under the Direct Bill Plan except the professional employees who lose their employment because of RIF (See Part IV.G.)

NOTE: Direct Bill participants lose their eligibility when the subgroup where the participant was last employed prior to enrolling in the Direct Bill Plan leaves the EHA plan.

A. Retirees 65 and Older

Retiring persons aged 65 and older, insured under the school employees' plans will be eligible for a group Medicare supplemental program offered by NSEA.

Early retirees between the ages of 50 through 64 who choose the Direct Bill Plan may join a Medicare supplement plan at age 65 by contacting BCBSNE's Lincoln office.

B. Leave of Absence--Disability

The active employee on total and permanent disability as defined by Social Security, the Nebraska Teacher Retirement System or the Omaha Public Schools Retirement System, may continue coverage on the Direct Bill Plan after 29 months' COBRA coverage by joining NSEA, NCSA or NASB as a Special Services member, unless otherwise required by the Family and Medical Leave Act of 1993. Disabled employees may enter the Direct Bill Plan after 18 months of COBRA. After completing 18 or 29 months' COBRA coverage, if the disabled employee has family coverage and has no eligible dependents, the employee and his or her spouse may apply for employeeplusspouse coverage. The active employee on total and permanent disability as defined by Social Security, the Nebraska Teacher Retirement System or the Omaha Public Schools Retirement System that is also on Medicare Part A and B, may also elect Medicare Supplemental coverage.

C. Leave of Absence--Non-Disability

Active employees on leave of absence for child rearing, sabbatical leave, etc., may continue coverage under COBRA for a period of 18 months, unless otherwise required by the Family and Medical Leave Act of 1993.

D. Active Member Whose Employment Status is in Question

In case of a dispute, if NSEA, NCSA or NASB is providing legal assistance to resolve an employment dispute, the Active Member of NSEA and NEA, NCSA or NASB can retain BCBSNE coverage by electing COBRA for 18 months followed by coverage on the Direct Bill Plan for the duration of the dispute.

E. Terminated Employment of Active Member

If no litigation is pending, the member may continue BCBSNE coverage through COBRA for 18 months. These persons are not eligible to remain on the group billing past the termination of their employment.

F. Widow/Widowers and Dependents of Deceased Employees

After the COBRA period, the covered widow/widower and dependents of a deceased employee may apply for Direct Bill coverage. Eligible dependents may remain on the coverage as long as they are on the family plan with the widow/widower. If the deceased employee's widow or widower should remarry, the new spouse and dependents would not be eligible for coverage under this plan. Widows/widowers over the age of 50 may enroll directly into the Direct Bill program without prior enrollment in the COBRA plan.

G. Coverage Loss due to RIF

Professional employees who were members of NSEA, NCSA or NASB at the time of loss of their employment due to reduction in force (RIF) and who are not otherwise eligible for coverage under the Direct Bill Plan, are eligible for six months of such coverage after the 18-month COBRA period. To be eligible, the employee must notify NSEA, NCSA or NASB at the time of termination of employment and once again at the end of COBRA. Eligibility for the six-month period ends if the subscriber accepts employment with an employer offering group health insurance. These employees do not have to become members of NSEA, NCSA or NASB Special Services during the six months of Direct Bill coverage.

V. Continuation of Coverage Options for Early Retirees

Retired Professional and other school employees aged 50 through 64 (or who are receiving benefits under either a school district board policy or a collectively-bargained agreement providing an early retirement program) are eligible to elect either the Direct Bill Plan or COBRA coverage at the time of retirement, and those employees with dependent coverage may apply for two Employee Only coverage's, one for the employee and one for the spouse. Members may also apply for any one of the coverage and rate tiers including dependent coverage. If COBRA is elected, these persons do not have the option of enrolling in the Direct Bill Plan after exhausting their COBRA coverage, except for the following: Persons who elect COBRA following an involuntary termination that qualifies them as Assistance Eligible Individuals (AEI) under the American Recovery and Reinvestment Act of 2009 (ARRA), shall be eligible for the Direct Bill Plan following COBRA coverage, provided that all other eligibility requirements are satisfied, and a completed enrollment application is received within 30 days of the end of COBRA coverage.

Eligibility information is as follows:

A. COBRA

The spouse and/or dependents who are part of the group health plan at the time of retirement shall be eligible to continue coverage under COBRA for 18 months (or, if applicable, 29 months).

B. Direct Bill

To be eligible for the Direct Bill Plan as an early retiree, the subscriber, his/her spouse and dependents must have a minimum number of months of continuous coverage under the EHA group health plan at the time of leaving the subgroup.

Last Day Effective With the Group	Minimum Number of Months
Prior to 10-31-1998	1 month
10-31-1998 through 9-30-1999	12 months
10-31-1999 through 9-30-2000	24 months
10-31-2000 through 9-30-2001	36 months
10-31-2001 through 9-30-2002	48 months
10-31-2002 and thereafter	60 months

If a school or an educational group joins the EHA Plan, their subscribers who are currently on early retirement can join the Direct Bill Plan without the minimum

number of months of continuous coverage. However, the subscribers who are active must meet the minimum number of months. BCBSNE will count the months of coverage with another insurance carrier prior to the EHA Plan to meet these requirements.

For active employees as of September 1, 2008, any dependents added through the Open Enrollment period (May 1, 2008 through September 30, 2008) with an effective date of September 1, 2008, will be eligible for coverage for early retirees under Section V. of the Underwriting Guidelines as long as the active employee has at least 60 months of continuous EHA coverage at retirement. The current 60 month rule will be waived only for those dependents enrolling during this Open Enrollment period, who then must maintain continuous EHA coverage. There will be no waiver of the 60 month continuous coverage requirement for any employees. This provision does not apply to members enrolling via special enrollment or for members enrolling at any time other than during the Open Enrollment period.

The minimum number of months' requirement may be adjusted slightly for employees whose contracts do not end on September 1.

The requirement for the minimum number of months may be decreased for spouses and dependents added as Special Enrollees, or who become a subscriber due to a prior qualifying event.

C. Temporary Separation from the EHA Program

Subscribers who leave the EHA program after meeting the 60 month minimum coverage period for early retiree eligibility and who return to the program after being away for no more than 24 months shall once again be eligible for the Direct Bill Retiree program once the return to service equals the number of months in which the member was not enrolled, (providing all other requirements of Part V.B. are met).

Subscribers who leave the EHA program after meeting the 60 month minimum coverage period for early retiree eligibility and who return to the program after being away will receive credit for their prior EHA coverage in determining current eligibility. For a subscriber to receive this prior coverage credit the following criteria must be met:

1. The subscriber must have had continuous health coverage.

2. There can be no more than a 63 day break in coverage in determining the continuous criteria above.

3. The subscriber must request the coverage credit in writing within 180 days of application for Direct Bill coverage.

4. The subscriber will be required to provide proof of other coverage. If creditable proof cannot be established the prior coverage credit will not be approved.

The following will be utilized in calculating the prior coverage credit:

For every five (5) years of prior EHA coverage the member will be credited with one (1) year of coverage. The maximum amount of credit will be three (3) years.

D. Dependents

If the employee has a spouse and/or eligible dependent children under age 26, he or she may continue coverage in any one of the coverage and rate tiers including dependent coverage, so long as there are eligible dependent children covered under the plan.

E. Persons Who Reach 65 Years of Age

Persons who reach 65 years of age and are no longer active employees are not eligible to remain on the Direct Bill Plan, unless the provisions of Part V.C. apply.

F. Applications

Applications received requesting the addition of spouses or dependents by employees or former employees on the Direct Bill Plan will be refused, unless such request is for a Special Enrollment. Also see Part IV.F. for widow/widower restrictions.

G. Benefit Options and Selection

As of September 1, 2010, members who are eligible to participate in the Direct Bill Retiree program will have the option of electing coverage from one (1) of three (3) benefit plan designs.

Once a plan design is selected the member will be allowed to change the coverage plan choice after three (3) years. However, if a member has a HIPAA qualifying event, a new plan design option may be selected within 31 days of the event's occurrence.

VI. Continuation of Coverage Options in the Case of School Closings

In the event of a school closing, affected members may continue coverage through the Direct Bill Program for 24 months. COBRA coverage is not available to members whose school closed and was not absorbed into another district. Other provisions regarding early retirement will still apply to these members.

VII. Benefit Options

A. Group Benefit Options

Each subgroup must select one of the available single option or dual option PPO benefit plans, listed below, which shall include the Utilization Management Program (UMP). This Program includes Inpatient Notification and Preadmission Certification. The subgroup's decision concerning the coverage for the professional staff is to be controlled by the agreement between the subgroup and the teachers.

Single Option Plans

1. $350 deductible PPO plan.
2. $600 deductible PPO plan.
3. $800 deductible PPO plan.

4. $1,100 deductible PPO plan.
5. $5,000 deductible reduced benefit PPO plan.

Dual Option Plans

1. Choice Plan A: The $350 deductible paired with the $1,500 deductible plan.
2. Choice Plan B: The $350 deductible paired with the $2,850 deductible HSA eligible plan.
3. Choice Plan C: The $600 deductible paired with the $1,500 deductible plan.
4. Choice Plan D: The $600 deductible paired with the $2,850 deductible HSA eligible plan.

The $1,500 deductible and the $2,850 deductible HSA eligible plans are not available on a stand-alone basis.

If the School Group Application for a subgroup is not received by August 1, 2011, the subgroup will continue on their current plan at the renewal premium rate on September 1, 2011.

A subgroup may have two groups: one for professional staff members (teachers and administrators), and one for classified staff members. Each group must have at least three eligible employees participating in the BCBSNE coverage.

If a subgroup negotiates with multiple unions of employees and negotiates different health or dental coverage for each union, each union may have their own subgroup. Each subgroup must have at least three employees participating in the BCBSNE coverage.

Subgroups that change their coverage options will not be subject to additional Waiting Periods for Pre-existing Conditions. The transfer must be made by submitting a signed and dated School Group Application.

B. Direct Bill Plan

The options available to the Direct Bill participants are as follows:

1. $600 deductible PPO plan.
2. $1,500 deductible PPO plan.
3. $2,850 deductible HSA eligible plan.

VIII. Dental Coverage

EHA endorses five options for dental coverage, including three PPO options and two indemnity options. The standard option is a PPO plan featuring benefits for preventive, diagnostic, maintenance and restorative services. The dental options are described in the Master Group Application and/or the School Group Application.

If this coverage is voluntarily cancelled, an Employee/Member and his or her eligible dependents may re-enroll for coverage during the Annual Enrollment Month. Coverage for the first year following the Annual Enrollment Month will be limited to Coverage A only and premiums will not be reduced.

Employees may change their membership unit for dental coverage from a multi-party membership to Employee Only coverage any time during the year (with approval from the subgroup). The employee may also change from Employee Only to multi-party membership dental coverage following a life event (e.g. marriage, divorce, addition of a newborn or adopted child).

IX. Requirements for Enrolling New Educational Subgroups

Public school districts and other public educational subgroups not currently enrolled in the EHA group health plan may apply for coverage by submitting a completed Request for Proposal form. The plan reserves the right to accept or reject any school district/subgroup with more than 50 employees, which applies for coverage in the group health plan. The purpose of these group enrollment requirements are to protect all members of the EHA program from the adverse selection that may occur if groups move in and out of coverage, and to assure each new group has its rates and eligibility determined in a fair and consistent manner, in accord with standard underwriting principles.

A. Subgroups with 100 or More Full-time Employees

BCBSNE will require experience from the prior group health insurance plan in force for such school districts and other subgroups. The group must complete and submit the appropriate "Medical Questionnaire" with the signature of the group representative. The Group Underwriting Department shall determine whether the group will be eligible to enter the group health plan at the current rates. This determination will include application of current BCBSNE underwriting techniques including but not limited to the current experience rating formula. The EHA insurance consultant will review the results of the underwriting and experience rating process and reach agreement with BCBSNE on the results. The results reviewed will include assurance that standard underwriting and rating approaches were fairly and consistently applied and in concurrence with the rate calculation. If the rate calculation results in premium rates needed in excess of the EHA premium rates, a surcharge will be applied equivalent to the difference in the two rates. The premium surcharge percentage will not change for three years. After three years, the group's premium rates will be equivalent to the standard EHA rates. The experience of individual groups, once in the EHA pool, will not be reviewed to determine continuation or termination of the premium surcharge either before or after the expiration of three years in the pool.

B. Subgroups with More than 50 but Fewer than 100 Full-time Employees

If experience from the prior group health insurance plan is available, it should also be submitted to BCBSNE, but experience information is not a requirement for eligibility in the EHA plan. All other provisions of Part IX.A. apply.

C. Subgroups of Fewer than 51 Full-time Employees

All of the provisions of Part IX.A. and B. apply, with the following exceptions:

1. Each employee must submit to BCBSNE an individual underwriting questionnaire for rating and reinsurance purposes.

2. If the rate calculation results in a surcharge of any amount greater than 15%, a 25% surcharge will apply.

None of the Protected Health Information required by this section shall be shared with EHA and shall be protected by BCBSNE, subject to the HIPAA requirements.

D. Standard Underwriting Practices

Standard group underwriting practices are applicable for Part IX.A., B., and C. This includes but is not limited to minimum participation and employer contribution, which are used to determine whether a school district or other subgroup shall be eligible for enrollment. Practices are subject to all federal and state law.

E. Employer Contribution per Eligible Employee

The employer's contribution for each eligible employee will be 50% of the single premium, including the premium surcharge.

F. Eligibility of Former EHA Subgroups

Individual subgroups leaving the plan will not be eligible for re-enrollment for two plan years following departure from the EHA plan.

G. Notice of New School Group Applications

BCBSNE shall notify EHA in a timely manner of any new subgroups being considered for enrollment in the plan.

X. Miscellaneous Provisions

A. The EHA Board or the Board's designee and representatives from BCBSNE will meet periodically to review the status of the group.

B. The EHA Board or the Board's designee will consult with BCBSNE before allowing or endorsing other carriers to offer health insurance (either group or individual policies) to its members, to ensure that such policy does not encumber coverage provided by BCBSNE.

C. Each employer retains responsibility for compliance with state and federal laws pertaining to employee health benefit plans.

D. This Agreement supersedes all previous agreements between the parties with respect to the subject matter herein. In the event any provision of this Agreement is rendered invalid or unenforceable, the remainder of the provisions of this Agreement shall remain in full force and effect. A provision in the covered person's benefit plan document will override an inconsistent provision in this Agreement.

E. No changes in this Agreement will be valid unless approved in writing by an executive officer of each of the parties. Any such change shall be effective on the date of the change.

F. The parties agree that all School Group Applications, utilization reports and medical expense/experience data are proprietary information for the use of both parties, and such data will not be provided to the individual schools without written consent of both parties.

G. Utilization data for various classifications of employees within the Direct Bill Plan will be made available to the EHA Board of Directors effective September 1, 2006.

H. No employer with an EHA participating subgroup may make contribution for or provide payroll deduction for payment of premiums, or in any other way sponsor a group health plan for any subset of employees other than the EHA and BCBSNE plan covered by this Agreement.

I. The failure or any delay on the part of a party to this Agreement to exercise any right, power or privilege under this Agreement shall not operate as a waiver of such right, power or privilege.

J. The parties agree that BCBSNE will audit subgroups as BCBSNE determines necessary to verify all subgroups are treated consistently and in compliance with all aspects of this agreement.

XI. Term of the Agreement

This Agreement shall continue in effect for a term of 12 months beginning September 1, 2011. The parties agree that the terms of this Agreement will be reviewed, updated and signed annually in conjunction with the Master Group Application.

XII. Termination and Reinstatement

The parties agree that this Agreement may be terminated by either party without cause. Six months written termination must be given to the other party. Termination will be effective on the first day of the month following the end of the six month notice period. If this Agreement is not revised annually, it will automatically be renewed for the succeeding 12-month period.

XIII. Independent Licensees

EHA on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between EHA and BCBSNE, that BCBSNE is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BCBSNE to use the BCBS Service Marks in Nebraska, and that BCBSNE is not contracting as the agent of the Association. EHA further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSNE, and that no person, entity, or organization other than BCBSNE shall be held accountable or liable to EHA for any of BCBSNE's obligations to EHA created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNE other than those obligations created under other provisions of this Agreement.

XIV. Relationship with Insurance Contract

For ease of reference, these guidelines summarize or address provisions which are also covered in the insurance contract. In the event of any conflict, the terms of the insurance contract control. Additionally, this underwriting agreement does not confer any benefits or rights on participants, providers or any parties other than EHA and BCBSNE.

EDUCATORS HEALTH ALLIANCE (EHA)

By:_____

Title:_____

Date:_____

BLUE CROSS AND BLUE SHIELD OF NEBRASKA (BCBSNE)

By:_____

Title:_____

Date:_____