UTILITY WORKERS' UNION OF AMERICA

NATIONAL HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION FOR UTILITY LINES CONSTRUCTION SERVICES, INC. – IBEW LOCAL UNION 204 BARGAINING UNIT EMPLOYEES

December 2018

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INTRODUCTION

We are the Board of Trustees of the Utility Workers' Union of America National Health & Welfare Fund ("Fund") which sponsors the Utility Workers' Union of America National Health & Welfare Plan ("Plan").

This Summary Plan Description (SPD) summarizes your and your family's Plan benefits -- medical, pharmacy, dental, vision, life, accidental death and dismemberment and disability benefits -- as of December 1, 2018. These Plan benefits provide comprehensive healthcare coverage and help to protect you against catastrophic healthcare expenses.

This December 1, 2018 SPD replaces and supersedes any prior Summary Plan Description issued by this Fund. It includes all Plan changes made since the last SPD was printed. This SPD, along with other Plan documents, govern the Plan's operation.

GRANDFATHERED PLAN STATUS

This Plan intends to comply with the standards necessary to maintain its Grandfathered status. This means that certain provisions of the Affordable Care Act are not provided by this Plan. See the Grandfathered Notice in Appendix A for more details.

NO BENEFITS ARE GUARANTEED

No Plan benefit is guaranteed. Among other things, we may amend, modify or eliminate any Plan benefits, and/or change the Plan's eligibility rules.

SOLE AUTHORITY TO INTERPRET THE PLAN

We have the *sole authority and discretion* to interpret all Plan documents and to make the final determinations regarding, for example, eligibility and benefits.

Stated another way, no Employer, Union nor any Employer or Union representative, is authorized to interpret the Plan. Nor can any such person act as the Trustees' agent.

You may only rely on Plan information that is in writing and signed by the Board of Trustees or by the Administrator, whose signature must be authorized by the Trustees.

READING THIS SPD

Read this SPD carefully to understand what Plan coverage is available, who's eligible for coverage and when Plan coverage begins and ends. If you're married, or have other covered dependents, share this SPD with them.

To assist you when reading the SPD, please consult the **Definitions** section for each benefit provided in this SPD.

Providing timely and accurate information to the Plan is your responsibility. All changes in your dependents must be in writing and supported by appropriate documentation (birth certificate, marriage certificate, etc.) Also notify the Fund Office in writing of any change in your address.

Further, if you wish to change your life insurance beneficiary, you must do so in writing. For more details, contact the Fund Office.

Note: The Fund Office and your local union (or participating employer) are separate entities. Therefore, you must separately notify your local union of an address change.

Finally, if you have questions about this SPD or about the Plan, please contact the Fund Office at 517-321-7502 or 800-920-8116.

You should keep this SPD with your other important papers.

Sincerely,

THE BOARD OF TRUSTEES OF THE
UTILITY WORKERS' UNION OF AMERICA
NATIONAL HEALTH AND WELFARE PLAN

SECTION 1 — GENERAL PLAN INFORMATION

PLAN ADMINISTRATION

Plan Name
Utility Workers' Union of America National Health & Welfare Plan

Plan Administrator
Board of Trustees
Utility Workers' Union of America National Health & Welfare Plan
6525 Centurion Drive
Lansing, Michigan 48917-9275
(517) 321-7502
800-920-8116

Employer Identification Number
20-0027580

Plan Number
501

Plan Year
For governmental filing and reporting purposes, the official plan year for the Utility Workers' Union of America National Health & Welfare Plan is January 1 through December 31.

Type of Plan
This Plan is a self-funded plan for medical, pharmacy, dental and vision benefits. This means that the Fund accepts full liability for the payment of claims and related expenses. Benefits for life, accidental death and dismemberment and long-term disability benefits are fully insured. This means that the Fund pays a premium for these benefits and the Fund's carrier assumes financial responsibility.

Plan Trustees
The Utility Workers' Union of America National Health & Welfare Plan is maintained and administered by a Board of Trustees of which labor and management are equally represented. There are five (5) Labor Trustees and five (5) Management Trustees on the Board. These "Plan Trustees" have the primary responsibility for decisions regarding the eligibility provisions, type of benefits, administrative policies, management of Fund Assets, and interpretation of Fund provisions.

Detailed information about the Plan Trustees is located in Appendix B of this SPD.

TYPE OF ADMINISTRATION

The administration of the Plan is under the supervision of the Plan Administrator. The Board of Trustees is the legally designated Plan Administrator. To the fullest extent permitted by law and applicable contracts, the Plan Administrator has the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator also has the discretion to determine all matters relating to interpretation and operation of the Plan and to make factual

determinations. Any determination by the Plan Administrator, or any authorized delegate, is final and binding.

As Plan Administrator, the Board of Trustees has delegated many of the day to day functions to a third-party administrator, TIC International Corporation (the Fund Office), and to the various health care, dental and vision benefit providers.

- TIC International Corporation maintains the eligibility records, accounts for employer contributions, and performs other routine activities under the direction of the Trustees.
- The benefit providers process claims, keep participants informed about Plan changes and perform other routine activities under the direction of the Trustees for the health care, prescription drug coverage, dental and vision benefits.

Collective Bargaining Agreements and Participation Agreements
The Fund was established and is maintained under the terms of collective bargaining agreements (CBA). Participation Agreements are also used to establish benefits for certain employers. These agreements set forth the conditions under which employers are required to contribute to the Fund and the rate of contributions and/or any other conditions for participation in the Plan. Upon written request, Employees may examine the agreements at the Fund Office or at other specified locations. Employees may request a copy of the agreements which will be provided to them at a reasonable charge.

Plan Sponsors
The Plan is maintained under the terms of collective bargaining agreements and participation agreements negotiated by the Union with participating employers. Employers who agree in writing to make contributions to the Fund are considered "plan sponsors." If any employer is not a party to a written agreement, then the employer generally has no legal obligation to contribute to the Fund on behalf of Employees. Consequently, to obtain benefits under this Fund, Employees must be working for a contributing employer. If there is any uncertainty determining whether or not an employer is a contributing employer, your Union Office should be contacted.

Upon written request, the Board of Trustees will confirm whether a particular employer or employee organization is a sponsor of the Plan. The Board of Trustees will also provide the address of plan sponsors.

SOURCE OF CONTRIBUTIONS

The primary source of financing for the benefits provided under this Fund and for the expenses of Fund operations is employer contributions. The rate of contribution is detailed in the collective bargaining agreement and/or participation agreement negotiated by the Union with participating employers. You may be required to pay a portion of the cost of coverage as noted in the Employee Payments section.

FUND MEDIUM FOR THE ACCUMULATION OF FUND ASSETS

All contributions and investment earnings are accumulated in a trust fund.

NAME AND ADDRESSES OF HEALTH CARE PROVIDERS AND INSURERS

Medical and Pharmacy Benefits
BLUE CROSS BLUE SHIELD OF MICHIGAN
600 E. Lafayette Blvd.
Detroit, MI 48226
313-225-9000 www.bcbsm.com

Dental Benefits
DELTA DENTAL
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149. www.deltadental.com

Vision Benefits
VISION SERVICE PLAN SERVICE COMPANY
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195 www.vsp.com

Life Insurance, Accidental Death and Dismemberment (AD&D) and Long-Term Disability (LTD) Benefits
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
555 Old S. Woodward, Suite 501
Birmingham, MI 48009
800-422-3902 www.guardiananytime.com

AGENT FOR SERVICE OF LEGAL PROCESS

If, for any reason, you wish to seek legal action, you may serve legal process on the Plan Administrator by delivering it to the Agent for Service of Legal Process at the following address:

Christopher P. Legghio
Legghio & Israel, P. C.
306 South Washington Avenue, Suite 600
Royal Oak, MI 48067-3837
(248) 398-5900

Service of legal papers also may be made directly upon the Plan Administrator.

SECTION 2 — PLAN ELIGIBILITY AND PARTICIPATION

ELIGIBILITY

Eligible Employees
Once you meet eligibility, the Plan provides benefits for you, your Spouse and your Eligible Dependents, if applicable.

The Plan defines an Eligible Employee as an employee who meets the Initial Eligibility Requirements below.

Your Spouse is your legal spouse.

Your Eligible Dependent is a dependent child who is related to you by birth, marriage, legal adoption or full legal guardianship. Dependent children are eligible for coverage through the last day of the month in which the dependent turns age twenty six (26). Also, children (of any age) are eligible for coverage, if totally and permanently disabled by either a physical or mental condition prior to reaching age twenty six (26).

Active Employees
Employees who receive employer contributions are deemed Active Employees. Employers pay contributions for health and welfare benefits based upon each hour you work (or as provided in your collective bargaining agreement or participation agreement).

Initial Eligibility Requirements
To meet the initial eligibility requirements, your employer must contribute to the Fund an amount that represents a minimum of one hundred forty (140) hours multiplied by the current contribution rate for at least two (2) consecutive months on your behalf. Only employer contributions can be used to meet the initial eligibility provisions.

Your eligibility for benefits begins on the first day of the month following a one (1) month accounting period after the initial eligibility requirements have been met. For claims to be covered, they must be incurred on or after the date your benefits begin.

For example, if you work for a contributing employer who remits at least one hundred forty (140) hours of contributions for each of the months of April and May at the current contribution rate for work performed by you, you become eligible for benefits on July 1 and remain eligible for the entire month of July.

Employee Payments
You may be required to pay a portion of the cost of coverage as provided in your CBA or Participation Agreement. This cost may be based upon your level of participation (i.e. single, couple or family) and can be adjusted as required by the Trustees. You will receive a notice reflecting the amount of the employee portion of coverage prior to its effective date, if applicable.

CONTINUATION OF ELIGIBILITY

Once you satisfy the Fund's initial eligibility requirements, you will remain eligible if:

- You continue to have at least one hundred forty (140) hours of employer contributions at the current rate made to the Fund in your behalf each month;

  OR

- You have at least one hundred forty (140) hours of employer contributions remaining in your hour bank which can be withdrawn to meet the monthly eligibility requirement.

Hour Bank System
Once you have met the initial eligibility requirements, the Fund uses an "hour bank" system for continuing eligibility. You can "bank" your employer contribution hours (bank hours) that exceed the Fund's monthly eligibility requirement. You accumulate bank hours in one-hour increments.

Using Your Bank Hours
Bank hours can be used to satisfy the Fund's eligibility requirements in a month in which you have not earned one hundred and forty (140) hours. Bank hours must be utilized in one-hundred and forty (140) hour increments to continue eligibility. Short hours are not accepted for eligibility. You may not accumulate more than two hundred eighty (280) hours or two (2) months of benefit eligibility under the Fund's hour bank.

For example, if you work 160 hours in a single month for which contributions are made to the Fund on your behalf, you can "bank" 20 hours. Once you have accumulated 140 bank hours, you can use them to meet the eligibility requirement for a month in which you have earned less than 140 hours. If you earn 120 hours in a month, you must use 140 bank hours to satisfy the eligibility requirement for that month. The Fund does not permit you to only use 20 bank hours (120 + 20 = 140) to maintain your eligibility.

Military Leave - USERRA Rights
Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than thirty-one (31) days, your Plan participation will not be interrupted. If the absence is for thirty-one (31) or more days and not more than twelve (12) weeks, you may continue to maintain your coverage under the Plan by paying premiums (prepayment or pay-as-you-go) for a twenty-four (24)-month period.

If you do not elect to continue to participate in the Plan during an absence for military duty that is thirty-one (31) or more days, or if you revoke a prior election to continue to participate for up to twelve (12) weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the Plan for the eighteen (18) -month period that begins on the first day of your leave of absence at the rate set by the Plan.

FMLA Leave
The Family Medical Leave Act (FMLA) provides certain employees, if eligible, with up to twelve (12) weeks of unpaid, job-protected leave per year. It also requires that your group health benefits be maintained during the leave as required by FMLA. An employer under a multi-employer plan must continue to make contributions on behalf of an employee using FMLA leave as though the employee had been continuously employed. Also an employee cannot be required to use bank hours. For more information about FMLA eligibility, contact your Employer.

Working Aged and Medicare Secondary Payer
If you continue to work beyond age sixty-five (65) and you are Medicare eligible, you are considered a "working aged" under the Medicare Secondary Payer guidelines. As a working aged, you have the option of choosing between Plan benefits or Medicare benefits as your primary plan. There are several options available including a possible delay of Part B and Part D prescription benefits without cost or penalties. Therefore, if you continue to work, you should contact the Social Security Administration at 800-772-1213 for assistance or visit the Medicare website at www.medicare.gov for complete details.

Note that as a "working aged," if you elect Medicare as your primary plan, health care benefits through the UWUA Health and Welfare Plan is prohibited for you and any dependents who may be enrolled in Medicare.

Your spouse and/or dependent(s) who become(s) eligible for Medicare benefits while you are an active worker must remain primary on your health care benefits.

RETIREMENT

Once you retire, you will no longer be eligible for health and welfare benefits through this Plan. You may, however, be able to continue limited coverage if you have remaining bank hours. You must have one-hundred and forty (140) bank hours available to continue coverage for one month. The maximum amount of bank hours that can be accrued is two-hundred and eighty (280) hours (two months of eligibility).

MEDICARE INFORMATION

Generally, Medicare eligibility begins at age sixty-five (65) or after twenty-four (24) months of receiving Social Security Disability Income benefits regardless of age, whichever comes first. Failure to enroll in Medicare in a timely manner may result in permanent penalties. In some cases, financial assistance may be available for low-income individuals. Conversely, high income earners may be required to pay additional premiums for Part B and Part D benefits as a Medicare enrollee. You should call the Social Security Administration at 800-772-1213 for assistance in understanding your Medicare benefits and any applicable premiums. You can also obtain detailed information by visiting the Medicare website at www.medicare.gov.

Medicare consists of several parts as follows:

> **Part A** – covers services such as hospital care, skilled nursing facilities, hospice care and some home health care benefits. For most individuals, there is no cost for Part A coverage.

Part B - covers medically necessary services and supplies that are needed to diagnose or treat a medical condition including inpatient and outpatient professional services, ambulance services and durable medical equipment. Most individuals will be required to pay for Part B coverage, which is either deducted from your Social Security benefit (if you are receiving Social Security) or a premium amount that you are required to pay if you are not receiving Social Security benefits. Premiums that are payable directly to Medicare are based on your income.

Part C - provides you with an opportunity to receive your Medicare benefits through a Part C program known as Medicare Advantage. Medicare Advantage consists of a variety of private health plans that cover Medicare Part A and Part B services and, in some cases, include Part D Prescription Drug services. Medicare Advantage plans are available through private insurers (not through Medicare). There may be a cost for a Medicare Advantage program. To fully understand how Medicare vs. a Medicare Advantage program work, visit the Medicare website at www.medicare.gov or contact a private insurer for assistance.

Part D - provides Prescription Drug benefits through private insurers (not through Medicare). Failure to timely enroll in a Part D program may result in penalties. Generally, you will be required to pay a premium for Part D benefits (low income individuals may be eligible for additional assistance). High income earners may be required to pay an additional premium directly to Medicare for Part D benefits based on income, which is either deducted from your Social Security benefits (if you are receiving Social Security) or for which you are required to pay if you are not receiving Social Security benefits**.**

Notice Of Medicare Eligibility

Approximately three months prior to your sixty-fifth (65^{th}) birthday (if you are not already enrolled in Medicare due to a disability), you should receive an Initial Enrollment Package from the Federal government which includes information about Medicare, a questionnaire, and your Medicare card. Your enrollment package should also include information regarding your rights and responsibilities under Medicare Part D Prescription Drugs. At that time, you can choose whether you want to participate in Medicare Part B and determine your options under Part D Prescription Drugs.

SECTION 3 — MEDICAL BENEFITS

BLUE CROSS BLUE SHIELD OF MICHIGAN MEMBER GUIDE

This Member Guide will help you and your family understand extra details of your Blue Cross Blue Shield of Michigan (BCBSM) health care program. By being well-informed, you'll have the confidence and security of knowing that health care coverage is available when you need it. This guide gives you an overview about your ID card, Explanation of Benefit (EOB) forms, web site information and other important phone numbers.

You can also find this information on line, along with detailed benefit information, by doing the following:

- Visit www.bcbsm.com and click *Login*
- Register to create your personal account

If you have technical difficulties in registering, please call BCBSM's Web Support at **888-417-3479 for assistance**.

YOUR BCBSM MEMBER ID CARD

Once you are enrolled, you'll receive a BCBSM ID card which contains the following:

1 **Enrollee name:** The contract holder's name

2 **Enrollee ID:** The contract holder's assigned contract number, which allows health care providers to identify you and your benefits

3 **Issuer:** Identifies you as a Michigan Blue Cross member to out-of-state providers

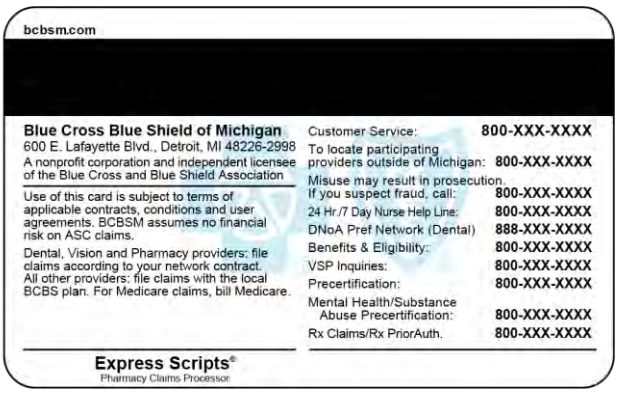
4 **Group number:** Identifies your employer group

5 & **6** These icons are present if your coverage includes dental or prescription drugs

Customer service phone numbers for you and your providers are located on the back of your member ID card.

Sample card front

Sample card back



Only you, your spouse and/or your eligible dependents may use the cards issued to you. Lending your card is illegal and subject to possible fraud investigation and termination of coverage.

Call BCBSM and inform them if your card is lost or stolen. Your provider can call BCBSM to verify coverage until you receive your new cards.
If you need additional ID cards:

- Visitwww.bcbsm.com and log in
- Click *Get an ID card*

You can also call the Customer Service number that is on the back of your ID card or you can call your Fund Office at **800-920-8116.**

MOBILE APP AND WEBSITE

BCBSM's mobile app and website provide resources to help you access information and make informed decisions from the convenience of your computer and phone.

Here are some of BCBSM's site and mobile app features:

Benefit details: See what your plan covers so you're more informed when you need care.

Deductible and out-of-pocket balances: Know how much you've paid toward your deductible and out-of-pocket maximum balances.

Access to pharmacy and drug information (for members with BCBSM pharmacy coverage): Look up drug prices, see coverage warnings and find lower cost alternatives.

View claims and EOBs: See what providers charged and why before you pay. Quickly filter and search claims by time frame, member, service type or provider.

Find a Doctor*:* Find a doctor or hospital in your network. *Search by location, specialties, quality recognitions and extended office hours. Get GPS–enabled directions.

Compare cost estimates: Compare cost information in real time for health care services.

Virtual member ID card: Show your virtual member ID card to your doctor for verification of coverage. Search BCBSM within the Apple® App Store or Google® Play and download the mobile app today.

How to create your online account

Once you receive your BCBSM member ID card, you're ready to create your online member account.

1. Go to www.bcbsm.com.
2. Click on the *Login* button at the upper right corner of the homepage.
3. Click on *Member*.
4. At the bottom of the box, click *Register Now*.
5. Follow the registration instructions.

How to download the bcbsm.com mobile app

1. Visit the Apple® App Store or Android Apps on Google® Play.
2. Search for "BCBSM."
3. Download the app to your device.
4. Register your account using your BCBSM ID card.

MEMBER DISCOUNTS WITH BLUE365

Save money and live healthier with Blue365

Blue Cross members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States. Member discounts with Blue365 offers exclusive deals on things like:

- **Fitness and wellness**: Health magazines, fitness gear and gym memberships
- **Healthy eating**: Cookbooks, cooking classes and weight-loss programs
- **Lifestyle**: Travel and recreation
- **Personal care**: Lasik and eye care services, dental care and hearing aids

Cash in on discounts

Start saving today. Show your BCBSM member ID card at participating local retailers or use an offer code online to take advantage of these savings. You can view all savings in one place through your member account at www.bcbsm.com. For a full list of discount offers log in or register at www.bcbsm.com and click *Member Discounts with Blue365* on the right side of your home page. You can also get monthly updates and details about new offers delivered directly to your email inbox. Just log in at www.bcbsm.com and opt-in to receive emails through *Paperless Options* under *Account Settings*.

CHOOSING YOUR PROVIDER

Looking for a doctor, hospital or other health care professional?
You can choose any health care provider in your network for routine or general care.
To assist in your search, visit www.bcbsm.com and click *Find a Doctor*. *This will* assist you in finding a provider who best matches your needs. With this application you can:

- Enter your preferred location
- Print your search results
- Easily compare providers
- Find out-of-state doctors
- Review specialty, board certification and education information
- Get cost estimates to help you research and compare certain procedures
- Find contact information
- Read a review of a doctor

You can also find a network provider for the following services on BCBSM's web site:

- Primary care services (routine exams or general health issues)
- Specialty care
- Behavioral care and substance abuse services
- Evening or weekend services
- Services from a doctor who speaks another language
- Services located near you

PREVENTING FRAUD

If your provider asks for another form of identification, don't worry. This is one way BCBSM's providers help protect you against unauthorized use of your card.

You can also help prevent fraud by checking your Explanation of Benefit Payments form. If you see a discrepancy on your EOB, contact your provider first to see if it's an error. If it's not and you believe it's a fraudulent billing or use of your card, call BCBSM's antifraud hot line at **800-482-3787**. You can also fill out BCBSM's online Anti-Fraud form or write to:

Anti-Fraud Unit, Mail Code B759
BCBSM
600 E. Lafayette Blvd.
Detroit, MI 48226

When reporting fraud, all phone calls and correspondence are confidential.

Keeping your health information secure
Expect confidentiality regarding your care. BCBSM will adhere to strict internal and external guidelines concerning your personal health information. This includes the use, access and disclosure of all information that is of a confidential nature.

Visit www.bcbsm.com/important.info.

- Click on *Keeping your health information secure*.

What you pay out-of-pocket
For details of the amount of out-of-pocket expenses you pay for covered services:

- Visit www.bcbsm.com and log in
- Click *My Coverage* and select either *Medical*, *Dental* or *Vision*
- Click *What's Covered*

If you have to pay for covered services, BCBSM will reimburse you for BCBSM's share of the cost. For more information and for a copy of the form:

- Visit www.bcbsm.com and log in
- Click *Forms*

HEALTH RESOURCES

Blue Cross® Health & Wellness

Your health and well-being are important. That's one of the main reasons your health care plan includes Blue Cross Health & Wellness, which helps you get healthy, stay healthy and improve your quality of life if you're living with an illness. This resource offers a 24-Hour Nurse Line that you can call with questions about your health. It also offers an effective disease management program to help you better manage your condition. In addition, if you have a specific health condition, a nurse health coach may contact you by phone or send information to you.

The Blue Cross Health & Wellness website, powered by WebMD®, offers a variety of helpful resources that can help you learn about your health risks and ways to stay healthy or improve your health. The Blue Cross Health & Wellness site includes:

- An easy-to-use online health assessment that gives you an analysis of your personal health risks and what you can do to improve your health
- Digital Health Assistant programs for exercise, nutrition, weight loss, tobacco cessation, stress relief and mental health that help you set goals and make small positive changes
- Health trackers so you can chart your healthy measures over time
- A Device and App Connection Center where you can sync your favorite fitness and medical devices and apps
- Message board exchanges that are professionally monitored
- Interactive programs such as calculators, guides, quizzes, slide shows and more
- Videos, recipes, articles, health encyclopedias and more

To access the Blue Cross Health & Wellness website:

1. Log in or register for www.bcbsm.com

2. Click on the *Health & Wellness* tab to enter the Blue Cross Health & Wellness website. You'll need to register for the website on your first visit.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan by providing health and wellness services.

BLUE CARD® PROGRAM

When traveling outside of Michigan, your coverage travels with you. Through the BlueCard program, you can find network and participating providers throughout the U.S. and around the world.

And, like network and participating providers in Michigan, you won't have to fill out claim forms or pay up front for the cost of the service unless it's an out-of-pocket cost such as a deductible, coinsurance and/or copayment, or a noncovered service.

Here are three steps to make the BlueCard program work for you:

1. In an emergency, go directly to the nearest hospital.
2. Call **800-810-BLUE (2583)** or access www.bluecardworldwide.com.
3. When you arrive at the network or participating provider's office or hospital, present your member ID card. The doctor or hospital will recognize the suitcase logo and know that you're receiving services under the BlueCard program. This means they'll submit any claim forms and only bill you for any deductible, coinsurance and/or copay that may be required by your health care plan.

Care away from home

Within the US

When you're traveling, you're covered through BCBSM's **BlueCard**[SM] program. BlueCard gives Blue Cross members seamless national access to the nine-two percent (92%) of physicians and ninety-six percent (96%) of hospitals that participate in Blue Cross Blue Shield networks. No matter where you live, work or travel, BCBSM members, through BlueCard, can continue to receive the high-quality care benefits of your plan. Remember, if the doctor or hospital is out-of-network, you could pay higher out-of-pocket costs; i.e., higher deductible, coinsurance and/or copayments.
To find a doctor or hospital outside of Michigan, you can use the *Find a Doctor* search tool at www.bcbsm.com**,** download and log on to our mobile app or call **800-810-2583**.

Outside the US

If you're traveling or living outside of the country, Blue Cross Blue Shield Global Core provides members with access to a network of traditional inpatient, outpatient and professional health care providers around the world. The program includes a broad range of medical assistance and claim support services for members traveling or living in countries outside their Home Plan service area. For more information, visit www.bcbsglobalcore.com.

Remember: Show your Blue Cross member ID card to your doctor or health care provider to verify your PPO benefits.

CLAIMS INFORMATION

With BCBSM's extensive network of participating providers and BCBSM's BlueCard® program, the only time you may have to file your own claims is if you receive services from a nonparticipating or non-network provider.

Filing a Claim

If you receive services from a nonparticipating or non-network provider, ask the provider if he or she will bill BCBSM for the services. Most providers will submit claims for their patients when asked.

If your provider won't bill BCBSM for you, follow these steps:

- Ask the provider for an itemized statement or receipt with the following information:
  - Name and address of provider
  - Full name of patient
  - Date of service
  - Provider's charge
  - Diagnosis and type of service
- Make a copy of all items for your files and send the originals to BCBSM with the claim form. It's important that you file claims promptly because most services have claims filing limitations. To find the form:
  - Visit www.bcbsm.com and log in
  - Click *Forms*
  - Note: If you receive care out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks or money order stubs may accompany your itemized receipts, but may not substitute for an itemized statement.

Payments for services will be made directly to you.

EXPLANATION OF BENEFITS (EOB)

Your Explanation of Benefits

After BCBSM processes claims for services you receive, BCBSM will send you an explanation of benefits, which is commonly referred to as an EOB. The EOB isn't a bill. It helps you understand how your benefits were paid. At the top of the EOB you'll find Blue Cross Blue Shield Customer Service numbers and an address to use for questions.

Receive Your Explanation of Benefits Electronically

Instead of receiving your EOBs in the mail, you can sign up to get them online. BCBSM will notify you by email when a new EOB has been posted. You can view, save or print your EOB statements.

- Visit www.bcbsm.com and log in.
- Click *Account Settings*.
- Click *Paperless Options*.

Reading your EOB

Briefly, your explanation of benefits tells you:

- The person who received the services and the date services were provided
- "Claim Summary" includes the providers of the services, and payments, including the amount saved by using network providers
- "Summary of Deductibles and Out-of-Pocket Maximums" shows your deductible and copayment requirements and a total of all deductibles and copayments paid to date
- "Claim Details" summarizes the Blue Cross payment and shows your balance
- Recent Claim Activity

If you see an error, contact your provider first. If your provider can't correct the error, call the Customer Service number on your EOB.

CUSTOMER SERVICE

To call BCBSM, please use the phone number printed on the back of your member ID card. You can also find this number on your EOB form. BCBSM's Customer Service hours are Monday through Friday from 8:30 a.m. to 5 p.m.

You can visit www.bcbsm.com to see if there's a walk-in customer service center near you for personal, face-to-face service.

BCBSM's goal is to provide excellent service. When you call, please be ready to provide BCBSM with your contract number. If you're inquiring about a claim, BCBSM will also need the following information:

- Patient's name
- Provider's name (hospital, doctor, laboratory, other)
- Date of service and type of service (surgery, office call, X-ray, other)
- Provider's charges

Please remember, Blue Cross Blue Shield of Michigan follows strict privacy policies in accordance with state and federal law. You'll find BCBSM's *Protected Health Information and Privacy Forms* at www.bcbsm.com/important.info.

Language Translation Services

When you call the Customer Service number on the back of your Blue Cross member ID card, you can request language assistance.

Assistance Speaking Your Language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث
إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話。

[illegible]

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오.

যদি আপনার, বা আপদন সাহাযয করছেন এমন কাছরা, সাহাযয প্রছ োজন হ , তাহছে আপনার ভাষা দবনামূছেয সাহাযয ও তথ্য পাও োর অদিকার আপনার রছ ছে৷ ককাছনা একজন কিাভাষীর সাছথ্ কথ্া বেছত, আপনার কাছডের কপেছন কিও া গ্রাহক সহা তা নম্বছর কে করুন৷

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng
tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

IMPORTANT DISCLOSURE

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with them, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: **CivilRights@bcbsm.com**. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & 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, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: **OCRComplaint@hhs.gov**. Complaint forms are available at *www.hhs.gov/ocr/office/file/index.html*.

Blue Cross Blue Shield Blue of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

YOUR HEALTH CARE BENEFITS

Community Blue PPO (CB-PPO) Medical Benefits

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts

are based on the Blue Cross Blue Shield of Michigan (BCBSM) approved amount, less any deductible, coinsurance and/or copayment that may be required. For a detailed description of benefits, please see the applicable BCBSM certificates, riders, and plan modifications (called the Plan Documents). If there is a discrepancy between this benefit summary and Plan Documents, the Plan Documents will control.

Preauthorization For Select Services
Services listed in this benefit summary are covered when provided in accordance with BCBSM policies and, when required, are preauthorized or approved by BCBSM. The following services require your provider to obtain approval before receiving these services – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, residential psychiatric facilities, rehabilitation therapy and applied behavioral analyses. Detailed information can be found at www.bcbsm.com/important.info.

Preauthorization For Specialty Pharmaceuticals
Select specialty pharmaceuticals may require preauthorization when received in locations such as a physician office, clinic, outpatient facility or through a home health care provider. Specialty pharmaceuticals are biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. These pharmaceuticals may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer. BCBSM determines which specific drug claims are payable. Contact BCBSM for a comprehensive list of specialty drugs by calling the number on the back of your BCBSM ID card.

Pricing Information
Pricing information for various procedures by **In-network** providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card. To allow the BCBSM customer service representative to assist in answering your question, you should be prepared to provide both the **procedure and diagnostic** code for the service in question. Your provider also has this information available upon request.

Work Related Injury
Coverage is excludable for service related to a work-related or occupational-related injury or illness. See limitations and exclusions.

COMMUNITY BLUE – PPO (CB-PPO) NETWORK-PROVIDERS

CB-PPO In-Network Providers:
Providers who have contracted with BCBSM's PPO program are termed "**In-network**" or "**Participating**" PPO providers. In other words, these providers are part of the BCBSM PPO network. If you use the services of a PPO network provider, you will be responsible only for deductibles, coinsurance and/or copayments as applicable for approved services.

CB-PPO Out-of-Network Providers:
Providers who have not contracted with BCBSM's PPO program are considered either "**Out-of-network**" or "**Non-participating**" providers. An Out-of-network provider is a provider who has not contracted with BCBSM as a PPO provider but has contracted with BCBSM as a "**Traditional**" provider. If you choose an "**Out-of-network**" provider for services, you will be

responsible for only the **higher** applicable deductibles, coinsurance and/or copayments if the **"Out-of-network"** provider is part of BCBSM's **Traditional** network.

Providers who are not contracted with BCBSM as either a PPO or Traditional provider are considered "Non-participating" providers. "Non-participating" providers may bill you for applicable deductibles, coinsurance and/or copayments **and** they can also bill you for balances that are greater than BCBSM's approved amount. These balances could be substantial. If a PPO provider "refers" you **Out-of-network** to a BCBSM **Traditional** participating provider, you will be liable only for **In-network** applicable deductibles, coinsurance and/or copayments. **A referral must be requested by your provider prior to your service.** If you are referred to a provider who does not participate in BCBSM's PPO or Traditional Network, you will be responsible for applicable deductibles, coinsurance and/or copayments **and** any charges billed by the provider that are greater than BCBSM's approved amount. These balances can be substantial.

Note: Approved services received from a provider for which there is no Michigan PPO network are covered at the "In-network" benefit level. Cost sharing may differ when you obtain covered services outside of Michigan. **Services received at a Non-participating facility, clinic or freestanding facility other than emergency services are not covered.**

COST SHARING REQUIREMENTS

Members' Responsibility – Deductibles, Coinsurance, Copayments and Dollar Maximums	**In-Network**	**Out-of-Network**
Deductible Maximums – calendar year **Note: Deductible may be waived for covered services, including mental health and substance abuse services deemed an office visit, that are performed in an In-network physician's office**	**$250** – Per Individual/ **$500** Per Family **Note:** In-network deductible amounts **do not** count towards the Out-of-network deductible maximums	**$250** Per Individual/ **$500** Per Family **Note:** Out-of-network deductible amounts **do** count towards the In-network deductible maximums
Percent Coinsurance – calendar year **Note: Coinsurance may be waived for services performed in an In-network physician's office**	**10%** of approved amount for most covered services; **50%** of approved amount for private duty nursing **Note:** Coinsurance amounts for private duty nursing do not count towards the coinsurance maximum	**20%** of approved amount for most covered services; **50%** of approved amount for private duty nursing
Fixed Dollar Copayments	**$20** copayment for select visits – including office visits, office consultations, urgent care visits and chiropractic/osteopathic spinal manipulation therapy **$50** copayment for emergency room services (waived if admitted or for an accidental injury)	**$0 –** fixed dollar copayments do not apply out-of-network **$50** copayment for emergency room services (waived if admitted or for an accidental injury)
Annual Coinsurance Dollar Maximums – calendar year **Note**: **Coinsurance for private duty nursing does not apply to the annual coinsurance maximum**.	**$1,000** Per Individual; **$2,000** Per Family (In-network coinsurance amounts **do not** count towards the Out-of-network coinsurance maximum)	**$2,000** Per Individual; **$4,000** Per Family (Out-of-network coinsurance amounts **do** count towards the In-network coinsurance maximum)
Out-of-Pocket Maximums – calendar year	**Not Applicable**	**Not Applicable**
Lifetime dollar maximum	None	

PLAN COVERED SERVICES

Preventive Care Services	**In-Network**	**Out-of-Network**
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	**100%** of approved amount (no deductible/ coinsurance/copayment)	Not Covered
	One routine per individual per calendar year	
Gynecological exam	**100%** of approved amount (no deductible/ coinsurance/copayment)	Not Covered
	One routine per individual per calendar year	
Pap smear screening – laboratory and pathology services	**100%** of approved amount (no deductible/ coinsurance/copayment) **Note:** Subsequent medically necessary pap tests performed during the same calendar year are subject to your deductible and percent coinsurance.	Not Covered
	One routine per individual per calendar year routine	
Voluntary sterilization for females	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	**100%** of approved amount after deductible.	**100%** of approved amount after deductible
Contraceptive injections	**90%** of approved amount after deductible	**80%** of approved amount after deductible and coinsurance
Well-baby and child care visits	**100%** of approved amount (no deductible/ coinsurance/copayment) • **8** visits, birth through **12** months • **6** visits, **13** months through **23** months • **6** visits, **24** months through 35 months • **2** visits, **36** months through **47** months • Visits beyond **47** months are limited to one per individual per calendar year under the health maintenance exam benefit	Not Covered
Childhood immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM **Note: Covered up to age nineteen (19)**	**100%** of approved amount (no deductible/ coinsurance/copayment)	Not Covered
Fecal occult blood screening	**100%** of approved amount (no deductible/ coinsurance/copayment)	Not Covered
	One routine per individual per calendar year	

Flexible sigmoidoscopy exam	**100%** of approved amount (no deductible/ coinsurance/copayment)	Not Covered
	One routine screening per individual per calendar year	
Prostate specific antigen (PSA) screening	**100%** of approved amount (no deductible/ coinsurance/copayment)	Not Covered
	One routine screening per individual per calendar year	
Routine mammogram and related reading	**90%** of approved amount after deductible **Note:** Subsequent medically necessary mammograms performed during the same calendar year are also subject to your deductible and percent coinsurance	**80%** of approved amount after deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an In-network provider.
	One routine screening per individual per calendar year	
Colonoscopy – routine or medically necessary	**90%** of approved amount (no deductible/ coinsurance/copayment) for the first billed colonoscopy in a calendar year. **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent coinsurance	**80%** of approved amount after deductible **Note:** Routine or medically necessary colonoscopies are subject to your deductible and percent coinsurance when received Out-of-network.
	One routine colonoscopy per individual per calendar year	
Physician Office Services	**In-Network**	**Out-of-Network**
Office visits	**100%** of the approved amount after **$20** copayment	**80%** of approved amount after deductible
Outpatient and home medical care visits	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Office consultations	**100%** of approved amount after **$20** copayment	**80%** of approved amount after deductible
Urgent care visits	**100%** of approved amount after **$20** copayment	**80%** of approved amount after deductible
Emergency Medical Care	**In-Network**	**Out-of-Network**
Urgent Care Clinic (Professional Services)	100% of approved amount (no deductible, coinsurance, copayment)	100% of approved amount (no deductible, coinsurance, copayment)
Physician's office	**100%** of approved amount (no deductible, coinsurance, copayment)	100% of approved amount (no deductible, coinsurance, copayment)
Hospital Emergency Room	**$50** copayment per visit (waived if admitted or for an accidental injury)	**$50** copayment per visit (waived if admitted or for an accidental injury)
Diagnostic Services	**In-Network**	**Out-of-Network**
Laboratory and pathology services	**90%** of approved amount after deductible	**80%** of approved amount after deductible

Therapeutic radiology	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Maternity Services – Provided by a Physician or Certified Nurse Midwife	**In-Network**	**Out-of-Network**
Prenatal care	**100%** of approved amount (no deductible/ coinsurance/ copayment)	**80%** of approved amount after deductible
Postnatal care	**100%** of approved amount (no deductible/ coinsurance/ copayment)	**80%** of approved amount after deductible
Delivery and nursery care	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Hospital Care	**In-Network**	**Out-of-Network**
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note: Nonemergency services must be rendered in a participating hospital.**	**90%** of approved amount after deductible	**80%** of approved amount after deductible
	Unlimited Days	
Inpatient consultations	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Chemotherapy	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Alternatives to Hospital Care	**In-Network**	**Out-of-Network**
Skilled nursing care – **Note: Services must be rendered in a participating skilled nursing facility**	**90%** of approved amount after deductible **Limited to 120 days per individual per calendar year**	
Hospice care – **Note: Services must be provided through a participating hospice program**	**100%** (no deductible/coinsurance/copayment) Up to **28** pre-hospice counseling visits before electing hospice services, elected four **90-day** periods, limited to a dollar maximum, that is reviewed and adjusted periodically (after reaching dollar maximums, a member may transition into individual case management).	
Home health care **–** **Note: Services must be provided by a participating home health care agency**	**90%** of approved amount after deductible	
Home infusion therapy – **Note: Services must be provided by a participating home infusion therapy provider or a participating freestanding ambulatory infusion center (AIC). Some drugs may require preauthorization.**	**90%** of approved amount after deductible	
Surgical Services	**In-Network**	**Out-of-Network**
Surgery – includes related surgical services. **Note: Services must be provided in a participating ambulatory surgical facility for facility costs to be covered.**	**90%** of approved amount after deductible	**80%** of approved amount after deductible

Pre-surgical consultations	**100%** of approved amount (no deductible/coinsurance/ copayment)	**80%** of approved amount after deductible
Voluntary sterilization for males **Note: See "Preventive Care Services" section for voluntary sterilizations for females.**	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Voluntary Abortions	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Human Organ Transplants	**In-Network**	**Out-of-Network**
Specified human organ transplants – **Note: Covered in designated facilities only and when coordinated through the BCBSM Human Organ Transplant Program** (1-800-242-3504)	**100%** of approved amount (no deductible/coinsurance/copayment)	
Bone Marrow Transplants **Note: Covered when coordinated through the BCBSM Human Organ Transplant Program** (1-800-242-3504)	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Specified oncology clinical trials **Note: Routine patient costs are not covered. Services must be provided in a Designated Cancer Center and must be preauthorized by BCBSM.**	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Kidney, cornea and skin transplants	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Mental Health Care and Substance Abuse Treatment **Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit, BCBSM will process the claim under office visit benefits.**		
Mental Health/Substance Abuse Care	**In-Network**	**Out-of-Network**
Inpatient mental health care and inpatient substance abuse services **Note: Services must be provided in a participating facility. Preauthorization is required.**	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Outpatient mental health care – facility and clinic **Note: Services must be provided in a participating facility/clinic.**	**90%** of approved amount after deductible	**80%** of approved amount after deductible **Note**: In-network cost-sharing will apply if there is not a PPO network
Residential psychiatric treatment facility **Note: Services must be provided in a residential psychiatric treatment facility. Preauthorization is required.**	**90%** of approved amount after deductible	**80%** of approved amount after deductible

Mental health and substance abuse physician services	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Mental health and substance abuse services deemed an office visit	**100%** of approved amount **$20** copayment	**80%** of approved amount after deductible
Outpatient substance abuse treatment facility **Note: Services must be provided in a participating facility**	**90%** of approved amount after deductible	**80%** of approved amount after deductible **Note**: In-network cost-sharing will apply if there is not a PPO network
Autism Spectrum Disorder, diagnoses and treatment **Note: Treatment must be preauthorized by BCBSM. Provider restrictions apply. Services require approval through a BCBSM approved autism evaluation center prior to receiving services.**	**In-Network**	**Out-of-Network**
Treatment of Applied Behavioral Analysis (ABA) for Autism - is covered through age eighteen (18) when rendered by an approved board- certified behavioral analyst.	**90%** of approved amount after deductible	
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for Autism Spectrum Disorder with an autism diagnosis – through age eighteen (18)	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Other covered services, including mental health services for Autism Spectrum Disorder	**90%** of approved amount after deductible	**80%** of approved amount after deductible
Other Covered Services	**In-Network**	**Out-of-Network**
Outpatient Diabetes Management Program (ODMP)	**100%** of the approved amount (no deductible/coinsurance/ copayment) for diabetes self-management training by a **Participating** provider; **90%** of approved amount after deductible for diabetes medical supplies	**80%** of approved amount after deductible for diabetes self-management training and for diabetes medical supplies
Allergy testing and therapy	**100%** of approved amount (no deductible/coinsurance/ copayment)	**80%** of approved amount after deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	**100%** of approved amount after **$20** copayment	**80%** of approved amount after deductible
	Limited to a maximum of **24** visits per individual per calendar year combined in-network and out-of-network	
Outpatient physical, speech and occupational therapy **Note: Services at non-participating, outpatient physical therapy facilities and non-participating freestanding facilities are not covered**.	**90%** of approved amount after deductible	**80%** of approved amount after deductible
	Limited to **60** visits per individual combined in-network or out-of-network.	
Durable medical equipment (DME)	**90%** of approved amount after deductible	

Prosthetic and orthotic appliances	**90%** of approved amount after deductible
Private duty nursing **Note: Must be preauthhorized by BCBSM**	**50%** of approved amount after deductible
Ambulance services	**90%** of approved amount after deductible

LIMITATIONS AND EXCLUSIONS

Note: The following is a list of common limitations and exclusions that may apply to your benefit plan. This list is not all inclusive. Additional limitations and exclusions may apply and can be found in your applicable BCBSM certificate, riders and plan modifications.

Hospital and Facility Care Inpatient Services Non-Payable:
Services received in a non-participating hospital or facility except emergency services
Services that may be medically necessary but can be provided safely in an outpatient or office location.
Custodial care or rest therapy.
Psychological tests if used as part of, or in connection with, vocational guidance training or counseling.
Dental services except as follows: Facility and anesthesia services may be payable if a hospitalized patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. In these cases, services are covered for the facility and anesthesia services only, not for the services of a dentist or other dental professional.
Screening services while in-patient.
Services covered under any other Blue Cross or Blue Shield contract or under any health care benefits plan except for Coordination of Benefits.
Dental implants and related services, including repair and maintenance of implants and surrounding tissue.
Non-contractual services through case management treatment plans when such services have not been approved by BCBSM.

Hospital Admissions Non-Payable:
Care that is not considered acute such as: • Observation • Dental treatment, including extraction of teeth except as noted above • Diagnostic evaluations • Lab exams • Electrocardiography • Weight reduction • X-rays, exams or therapy • Cobalt or ultrasound studies • Basal metabolism tests • Convalescence or rest care • Convenience care • Hospital Services mainly for physical therapy, speech and language pathology services or occupational therapy.

Hospital and Facility Care Outpatient Services Non-Payable:
Services provided by a non-participating hospital.
Services for mental health care that is beyond the period required to evaluate or diagnose mental health deficiencies or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards or in a skilled nursing facility.
Services in a non-participating ambulatory surgery facility except for emergency services (see Other Providers Non-Payable below)
Services provided by a non-participating end stage renal disease facility.
Services not provided by the employees of an end stage renal disease facility.
Services not related to end stage renal disease dialysis processes.
Home Health Care Services provided by a non-participating home health care agency.
Home Health Care Services Non-Payable are: general housekeeping services, transportation to and from a hospital or other facility, custodial care or non-skilled care, services performed by a non-participating home health care provider.

Cardiac or pulmonary rehabilitation services that require less than intensive monitoring (i.e., through the use of EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable.
Experimental or investigational items, devices or the service itself.
Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Other Providers Non-Payable:
Non-participating hospitals (except for emergency services at an accredited non-participating hospital), facilities or alternative to hospital care providers. Emergency services are paid at BCBSM's approved amounts.
Services received from non-participating facilities/providers including, but not limited to, outpatient physical therapy facilities, freestanding ambulatory surgery facilities, mental health or substance abuse treatment facilities, skilled nursing facilities, hospice programs, home health care agencies or infusion therapy providers.
Non-participating end stage renal disease facilities.
Services performed by a non-participating home health care provider.
Services provided at a non-participating skilled nursing facility.
Other Services Non-Payable:
Services that are covered by any other BCBSM certificate or under any other health care benefits plan except for Coordination of Benefits.
Services that are not covered because they are medically unnecessary, investigational or experimental.
Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
Treatment for gender dysphoria including prescription drug services and treatment that is considered experimental or investigational.
Physician Services Non-Payable:
Services for cosmetic surgery when performed solely to improve appearance.
Services provided by persons who are not eligible for payment or appropriately credentialed or legally authorized or licensed to order or provide such services.
Dental care except to treat an accidental injury or if an inpatient due to a medical necessity.
Pre-employment, pre-marital, school and sports physicals unless needed to diagnose or treat a specific disease, illness, pregnancy or injury.
Weight loss programs.
Services in a non-hospital institution except for approved home health care.
Services, care, supplies or devices not prescribed by a physician.
Non-contractual services described through a case management treatment plan not approved by BCBSM.
Services provided during non-emergency medical transport.
Experimental treatment.
Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards.
Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances unless you lack a natural lens. (See Vision benefits for payable vision services.)
Irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction except for surgery directly to the temporomandibular joint and related anesthesia services, diagnostic x-rays, arthrocentesis, approved physical therapy.
Self-treatment by a professional provider and services given to parents, siblings, spouse or children.
Alternative medicines or therapies such as acupuncture, herbal medicines and massage therapy.
Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable.
Infertility services such as sperm washing, post-coital test, monitoring of ovarian response to ovulatory stimulants, in vitro fertilization, ovarian wedge resection or ovarian drilling, reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility, diagnostic studies done for the sole purpose of infertility assessment, any procedure done to enhance reproductive capacity or fertility.
Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue, unless otherwise noted as an included benefit.

Rest therapy or services provided while in a convalescent home, long-term care facility, nursing home, rest home or similar non-hospital institution.
Sports medicine, pain management, patient education (except as otherwise specified) or home exercise programs.
Screening services (except as otherwise stated).
Services for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under your Certificate.
Services available in a hospital maintained by the state or federal government, unless payment is required by law.
Services payable by government-sponsored health care programs such as Medicare, for which a member is eligible. These services are Non-Payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal law requires the government-sponsored program to be secondary to this coverage.
Gender reassignment services that are considered by BCBSM to be cosmetic or treatment that is experimental or investigational.
Custodial and non-skilled care.
Services not listed in your certificate and riders as being payable.

Devices and Services Non-Payable:
Non-rigid devices and supplies such as elastic stockings, garter belts, arch supports and corsets.
Spare prosthetic devices.
Routine maintenance of the prosthetic device.
Prosthetic devices that are experimental.
Hair prostheses such as wigs, hair pieces, hair implants, etc.
Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners.
Exercise and hygienic equipment such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats.
Sauna baths, elevators, experimental equipment.

Time Limit for Filing Pay-Provider Medical Claims
BCBSM will not pay medical claims filed after the timeframe set out in the treating provider's participation agreement with BCBSM.
BCBSM's time limit for submitting a claim for payment for a "Non-participating" provider is twenty-four (24) months.

DEFINITIONS

Accidental Injury
Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or another insect bite
- Extreme frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
  Inhaling smoke, carbon monoxide or fumes
- Attempted suicide
- A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

Accredited Hospital
A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities (Also see the definition of "Hospital" in this section).

Acute Care
Medical care that requires a wide range of medical, surgical, obstetrical and/or pediatric services. It generally requires a hospital stay of less than 30 days.

Acute Care Facility
A facility that provides acute care. This facility primarily treats patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or those with substance use disorder
- Skilled nursing or other nursing care

Administrative Costs
Costs incurred by the organization sponsoring an approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Adverse Benefit Decision
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

Affiliate Cancer Center
A health care provider that has contracted with a NCI-approved cancer center to provide treatment.

Allogeneic (Allogenic) Transplant
A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.

Ambulatory Infusion Center
A freestanding outpatient facility that provides infusion therapy and select injections that can be safely performed in this setting.

Ambulatory Surgery
Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a physician's office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.

Ambulatory Surgery Facility
A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It is not an office of a physician or other private practice office.

Ancillary Services
Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the patient receives. They do not include room, board and nursing care.

Approved Amount
The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved Clinical Trial
Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- A federally-funded trial, as described in the Patient Protection and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the Food and Drug Administration
- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Care Act

Arthrocentesis
Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

Attending Physician
The physician in charge of a case who exercises overall responsibility for the patient's care:

- Within a facility (such as a hospital and other inpatient facility)
- As part of a treatment program
- In a clinic or private office setting

The attending physician may be responsible for coordination of care delivery by other physicians and/or ancillary staff.

Audiologist
A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

Autologous Transplant
A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

BCBSM
Blue Cross Blue Shield of Michigan.

Benefit Period
The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant related prescription drugs, must be provided during this period of time.

Biological
A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.

Birth Year
A 12-month period of time beginning with a child's month and day of birth.

BlueCard PPO® Program
A program that allows Blue Cross Blue Shield PPO members to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.

Blue Cross Blue Shield Global Core Program
A program that provides access to a network of inpatient facilities and medical assistance services worldwide including referrals to professional providers for all Blue Cross Blue Shield of Michigan members whose claims are eligible for processing through the BlueCard Program.

Blue Cross Plan
Any hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Distinction Total Care (BDTC)
A program that allows you to receive care management services outside the state of Michigan from a trained clinical care provider in a team effort with, and directed by, your primary care physician.

Blue Shield Plan
Any medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

Calendar Year
A period of time beginning January 1 and ending December 31 of the same year.

Cancellation
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

Carrier
An insurance company providing a health care plan for its members.

Case Management
A program that is designed to help manage the health care of members with acute or chronic conditions. It is up to BCBSM to decide whether you qualify for this program.

In certain circumstances, BCBSM may find it necessary to pay for services that are generally not covered by your contract but that are medically necessary to treat your condition. When this occurs, a case management contract must be signed by you (or your representative), your provider and the BCBSM case manager. This contract will define the services that will be covered under the case management program.

NOTE: If BCBSM has contracted with a vendor to manage the case management program, then that vendor will make decisions regarding case management and sign any necessary case management documents on behalf of BCBSM.

Certificate
This book, which describes your benefit plan, **and** any riders that amend it.

Certified Nurse Midwife
A nurse who provides some maternity, contraceptive, and other services and who:

- Is licensed as a registered nurse by the state of Michigan (MI)
- Has a specialty certification as a nurse midwife by the MI Board of Nursing
- Has current national certification as a midwife by an organization recognized by the MI Board of Nursing

Certified Nurse Practitioner
A nurse who provides some medical and/or psychiatric services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified nurse practitioner by the MI Board of Nursing
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

Certified Registered Nurse Anesthetist
A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified registered nurse anesthetist by the MI Board of Nursing
- Meets BCBSM qualification standards
- When outside of the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed

Chronic Condition
A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient's life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases.

Claim for Damages
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Clinical Licensed Master's Social Worker
A clinical licensed master's social worker who provides some mental health services and who:

- Is licensed as a clinical social worker by the state of Michigan.
- Meets BCBSM qualification standards.
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

Clinical Trial
A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, clinical trials include:

- Phase II - a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coinsurance
The portion of the approved amount that you must pay for a covered drug or service. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by an audit, adjustment, or recovery. For prescription drugs, your coinsurance is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Colony Stimulating Growth Factors
Factors that stimulate the multiplication of very young blood cells.

Congenital Condition
A condition that exists at birth.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends
- You lose coverage as a dependent of the covered employee, or
- Another qualifying event.

If you elect COBRA coverage, you pay 100 percent of the premiums, including the share the employer used to pay for you, plus a small administrative fee.

Contraceptive Device
A device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.

Contraceptive Medication
Any drug used for the express purpose of preventing pregnancy at the time of its administration.

Contract
This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Contracted Area Hospital
A BCBSM participating or in-network hospital located in the same area as a noncontracted area hospital.

Conventional Treatment
Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.

Coordination Period
A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.

Copayment
The dollar amount that you must pay for a covered drug or service. Your copayment is not altered by an audit, adjustment, or recovery. For prescription drugs, your copayment is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Cost–sharing
Copayments, coinsurances, and deductibles you must pay under this certificate.

Covered Services
A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

Custodial Care
Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

DAW (Dispense as Written)
An instruction on a drug prescription by a prescriber that requires the pharmacist to dispense only the drug named on the prescription.

Deductible
The amount that you must pay for covered services, under any certificate, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time of the claims are processed. Your deductible is not altered by an audit, adjustment, or recovery. For prescription drugs, your deductible is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Dental Care
Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.

Designated Cancer Center
A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

Designated Facility
To be a covered benefit, human organ transplants must take place in a "BCBSM-designated" facility. A **designated facility** is one that BCBSM determines to be qualified to perform a specific organ transplant. BCBSM has a list of designated facilities and will make it available to you and your physician upon request.

Designated Services
Services that BCBSM determines only a noncontracted area hospital is equipped to provide.

Detoxification
The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

Developmental Condition
A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.

Diagnostic Agents
Substances used to diagnose rather than treat a condition or disease.

Dialysis
The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.

Direct Supervision
The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Diversional Therapy
Planned recreational activities, such as hobbies, arts and crafts, etc., not directly related to functional therapy for a medical condition.

Dual Entitlement
When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

Durable Medical Equipment
Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

Effective Date
The date your coverage begins under this contract. This date is established by BCBSM.

Eligibility
As defined in the certificate under **End Stage Renal Disease**, eligibility means the member's right to Medicare coverage under Title XVIII of the Social Security Act, as amended. Otherwise, eligibility means the member's right to coverage under this certificate.

Emergency Care
Care to treat an accidental injury or medical emergency.

Emergency Medical Condition
A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- The health of the patient (or with respect to a pregnant woman, the health of the woman or her unborn child) to be in serious jeopardy, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or unborn child).

Emergency Services
Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital and includes ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff

and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

End Stage Renal Disease (ESRD)
Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal (kidney) failure.

Enrollment Date
The first date of coverage or, if there is a new hire waiting period, the first day of the waiting period.

Entitlement (or Entitled)
The member's right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.

Evaluation
An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

Exclusions
Situations, conditions, or services that are not covered by the subscriber's contract.

Exigent Circumstance
An exigent circumstance exists when you suffer from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a drug that is not on our approved drug list.

Experimental Treatment
Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."

Facility
A hospital or facility that offers acute care or specialized treatment, including, but not limited to, substance use disorder treatment, skilled nursing care or physical therapy.

Fecal Occult Blood Screening
A laboratory test to detect blood in feces or stool.

First Degree Relative
An immediate family member who is directly related to the patient: either a parent, sibling or child.

First Priority Security Interest
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Flexible Sigmoidoscopy
A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

Food and Drug Administration (FDA)
An agency of the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

Freestanding Outpatient Physical Therapy Facility
An independently owned and operated facility separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

Gender Dysphoria
A broad diagnosis that covers a person's emotional discontent with the gender they were assigned at birth. A clinical diagnosis is made when a person meets the specific criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Gender Reassignment Services
A collection of services that are used to treat gender dysphoria. These services may include hormone treatment and/or gender reassignment surgery, as well as counseling and psychiatric services. These services must be medically necessary to be payable by BCBSM. BCBSM will not pay for services that it considers to be cosmetic. BCBSM will also not pay for services that are experimental or investigational or for services that are not corrected under your Plan.

Group
A collection of members under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Gynecological Examination
A history and physical examination of the female genital tract.

Hazardous Medical Condition
The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

Health Maintenance Examination
A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hematopoietic Transplant
A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

Hemodialysis
The use of a machine to clean wastes from the blood after the kidneys have failed.

High-Dose Chemotherapy
A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

High-Risk Patient
An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers
Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home Health Care Agency
An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

Hospice
A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Hospital
A facility that:

- Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis **and**
- Is fully licensed and certified as a hospital, as required by all applicable laws **and**
- Complies with all applicable national certification and accreditation standards

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses.

NOTE: A facility that provides specialized services that does not meet all of the above requirements does not qualify as a hospital under this certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional children or for the treatment of the aged or of those with substance use disorder
- Skilled nursing facilities or other nursing care facilities

Hospital privileges
Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

Host Blue
See definition of "Host Plan."

Host Plan
A Blue Cross and/or Blue Shield plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state. Sometimes referred to as Host Blue.

In-Network Providers
Hospitals, physicians and other licensed facilities or health care professionals who provide services through this PPO program. In-network providers have agreed to accept BCBSM's approved amount as payment in full for covered services provided under this PPO program.

Independent Occupational Therapist
An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Physical Therapist
A physical therapist who provides some physical therapy services and who:

- Is licensed as a physical therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Speech-Language Pathologist
A speech-language pathologist who provides some speech-language therapy services and who:

- Is licensed as a speech-language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses, then a Certificate of Clinical Competence from the American Speech and Hearing Association is an acceptable alternative until the state issues licenses.
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Infusion Therapy
The continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

Injectable Drugs
Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician's supervision.

Irreversible Treatment
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- The treatment is intended to cause permanent change to a person's bite or position of the jaws.
- The treatment includes, but is not limited to:
  - Crowns, inlays, caps, restorations and grinding
  - Orthodontics, such as braces, orthopedic repositioning and traction
  - Installation of removable or fixed appliances such as dentures, partial dentures or bridges
  - Surgery directly to the jaw joint and related anesthesia services
  - Arthrocentesis

Jaw Joint Disorders
These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly
- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain and inability to move the jaw properly
- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly

Licensed Professional Counselor (LPC)
A licensed professional counselor who provides some mental health services and who:

- Is licensed as a professional counselor by the state of Michigan;
- Meets BCBSM qualification standards;
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Lien
A first priority security interest in any money or other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

Life-threatening Condition
Any disease or condition from which the likelihood of death is probable unless the course of the disease of condition is interrupted.

Lobar Lung
A portion of a lung from a cadaver or living donor.

Long-Term Acute Care Hospital
A specialty hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

Mammogram
A low dose X-ray of the breast, two views per breast. The radiation machine must be state authorized and specifically designed and used to perform mammography.

Mandibular Orthotic Reposition Device
An appliance used in the treatment of temporomandibular joint dysfunction.

Maternity Care
Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial Prosthesis
A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Maximum Payment Level
The most BCBSM will pay for a covered service. For participating or in-network providers, it is the amount BCBSM pays the provider under the provider's contract with BCBSM. For services provided by nonparticipating or out-of-network providers, it is the amount BCBSM pays for the service to its participating or in-network providers or the amount BCBSM negotiates with the nonparticipating or out-of-network provider. Maximum payment level is not a "Medicare-like rate" described in 42 C.F.R. §136.30, *et. seq*.

Medical Emergency
A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury. Emergency services treat medical emergencies.

Medical Evidence Report
A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD patient beginning dialysis.

Medically Necessary
A service must be medically necessary to be covered. There are two definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons) and other providers; another applies to hospitals and LTACHs.

- Medical necessity for payment of professional provider and other provider services:

Health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and
- Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

NOTE: "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.

- Medical necessity for payment of hospital and LTACH services:

Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment, or supply is **appropriate** for the symptoms and is consistent with the diagnosis.
- **Appropriate** means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

- The service is not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

Member
Any person eligible for health care services under this certificate on the date the services are rendered. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered drugs or services.

Network Providers
Also called "In-network providers". See the definition of "In-network Providers."

Newborn Care
Hospital and professional services that are provided to newborns during the initial stay following birth. This care includes the newborn examination, which must be given by a physician other than the anesthesiologist or the mother's attending physician.

Noncontracted Area Hospital
A BCBSM nonparticipating and out-of-network hospital located in an area defined by BCBSM.

Nonparticipating Hospital
A hospital that has not signed a participation agreement with BCBSM to accept BCBSM's approved amount as payment in full.

Nonparticipating Providers
Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational Therapy
A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- Develop, improve, retain or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury or following surgery;
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living; or
- Design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, shower chairs, large-handle eating utensils, lap trays and raised toilet seats).

Off-Label
The use of a drug or device for clinical indications other than those stated in the labeling approved by the Food and Drug Administration.

Online Visit
BCBSM-specified evaluation and management service delivered via the internet. Contact is initiated by you and must be within the provider's scope of practice. Online visits by an online visit vendor will not be covered.

Orthopedic Shoes
Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

Orthotic Device
An appliance worn outside the body to correct a body defect of form or function.

Out-of-Area Hospital
A BCBSM in-network or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

Out-of-Area Services
Services available to members living or traveling outside a health plan's service area.

Out-of-Network Providers
Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under this PPO program.

Outpatient Mental Health Facility
A facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.

Outpatient Substance Abuse Treatment Program
A program that provides medical and other services on an outpatient basis specifically for those with substance use disorder.

Pap Smear
A method used to detect abnormal conditions, including cancer of the female genital tract.

Partial Hospitalization Program (PHP)
Treatment for mental or emotional disorders provided by a hospital or OPC to a patient who lives at home and goes to a hospital or OPC.

Partial Liver
A portion of the liver taken from a cadaver or living donor.

Participating Hospital
A hospital that has signed a participation agreement with BCBSM to accept their approved amount as payment in full. Deductibles, copayments and/or coinsurance which may be required of you, are subtracted from the approved amount before we make our payment.

Participating PPO Provider
A provider who participates with the Host Plan's PPO.

Participating Providers
Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Any cost-share, which may be required of you, is subtracted from the approved amount before we make our payment.

Patient
The subscriber or eligible dependent that is awaiting or receiving medical care, treatment or covered drugs.

Pay-Provider Claim
This is a type of claim where Blue Cross pays your provider directly according to the terms of your coverage.

Pay-Subscriber Claim
This is a type of claim where Blue Cross will reimburse you, the subscriber, according to the terms of your coverage. Either you or your provider may submit this type of claim.

Per Claim Participation
Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

Peripheral Blood Stem Cell Transplant
A procedure in which blood stem cells are obtained by pheresis and infused into the patient's circulation.

Peritoneal Dialysis
Removal of wastes from the body by perfusion of a chemical solution through the abdomen.

Pheresis
Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).

Physical Therapist
A physical therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

Physical Therapy
The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to keep, learn, retain or improve:

- Muscle strength
- Joint motion
- Coordination
- General mobility

Physician
A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners." The term physician or practitioner may also include other types of professional providers when they perform covered services within their scope of practice.

Physician Assistant
A physician assistant is licensed by the state of Michigan to engage in the practice of medicine, osteopathic medicine and surgery, or podiatric medicine and surgery with a participating physician under a practice agreement.

Plaintiff
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Post-service Grievance
A post-service grievance is an appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

PPACA
The Patient Protection and Affordable Care Act enacted March 23, 2010.

Practitioner
A physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master's social worker, licensed professional counselor or oral surgeon) or other professional provider who participates with BCBSM or who is in a BCBSM PPO network. Practitioner may also be referred to as "participating" or "In-network" provider.

Preapproval
A process that allows you or your provider to know if proposed service will be covered before you receive them. If preapproval is not obtained **before** you receive certain services described in this certificate, they will not be covered.

Preapproval Process
A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board-certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine-month intervals or at other mutually agreed upon intervals after the onset of treatment.

Preferred Provider Organization (PPO)
A limited group of health care providers or pharmacies who have agreed to provide covered drugs or services to BCBSM members enrolled in the PPO program. These providers or pharmacies accept the approved amount as payment in full for covered drugs or services.

Pre-service Grievance
A pre-service grievance is an appeal that you can file when you disagree with BCBSM's decision not to pre-approve a service you have not yet received.

Presurgical Consultation
A consultation that allows a member to get an additional opinion from a physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon** when surgery is recommended.

Primary Payer
The health care coverage plan that pays first when you are provided benefits by more than one carrier (For example, you may have BCBSM group coverage and Medicare.).

Primary Plan
The health care plan obligated to pay for services before any other health care plan that covers the member or patient.

Primary Care Physician (PCP)
The physician you choose to provide or coordinate all of your medical care, including specialty and hospital care. A primary care physician is appropriately licensed in one of the following medical fields:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Professional Provider
One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Physician assistant (PA)
- Fully licensed psychologist
- Clinical licensed master's social worker (CLMSW)
- Licensed professional counselor (LPC)
- Oral surgeon
- Board certified behavior analyst
- Independent physical therapist (IPT)
- Independent speech therapist (IST)
- Independent occupational therapist (IOT)
- Certified nurse practitioner (CNP)
- Certified nurse midwife (CNM)
- Certified registered nurse anesthetist (CRNA)
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

Prosthetic Device
An artificial appliance that:

- Replaces all or part of a body part or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ.

Protocol
A detailed plan of a medical experiment or treatment.

Provider
A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care or a pharmacy legally licensed to dispense drugs.

Provider-Delivered Care Management (PDCM)
A program that allows you to receive care management services in Michigan from a trained clinical care manager in a team effort with, and directed by, your primary care physician.

Psychiatric Residential Treatment Facility
A facility that provides residents with 24-hour mental health care and treatment, seven days a week. The facility must participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

Psychologist
A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Purging
A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Qualified Beneficiary
Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualified Individual
An individual eligible for coverage under this certificate who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

- The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol, or
- The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols.

Qualifying Event
One of the following events that allows you to enroll in different health care coverage or change your current coverage or allows a beneficiary to receive coverage under COBRA:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Start of Military Service. Members must perform military duty for 31 or more days
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

NOTE: The examples in this definition are not exhaustive and may change. Please call Customer Service for more information about qualifying events.

Radiology Services
These include X-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

Referral
The process in which the PCP sends a patient to another provider for a specified service or treatment plan.

Refractory Patient
An individual who does not achieve clinical disappearance of the disease after standard therapy.

Registered Provider
A participating or nonparticipating provider (or In-network or Out-of-network PPO provider) that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Relapse
When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.

Remitting Agent
Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber; and
- Pay the subscriber's BCBSM bill.

Rescission
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

Research Management
Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.

Residential Substance Abuse Treatment Program
A program that provides medical and other services on a residential basis specifically for those with substance use disorder in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called "intermediate care."

Respite Care
Relief to family members or other persons caring for terminally ill persons at home.

Retail Health Clinic
A medical clinic located inside a retail store. It offers "walk-in" care for minor conditions, provided by a professional provider.

Reversible Treatment
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- This treatment is **not** intended to cause permanent change to a person's bite or position of the jaws.
- This treatment is designed to manage the patient's symptoms. It can include, but is not limited to, the following services:
  - Arthrocentesis
  - Physical therapy
  - Reversible appliance therapy (mandibular orthotic repositioning).

Rider
A document that changes a certificate by adding, limiting, deleting or clarifying benefits.

Right of Recovery
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Routine Patient Costs
All items and services related to an approved clinical trial if they are covered under this certificate (or any riders that amend it) for members who are not participants in an approved clinical trial. They do not include:

- The investigational item, device, or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sanctioned Prescriber
Any provider who has been disciplined under Section 1128 and Section 1902(a) (39) of the Social Security Act; excluded or suspended from participation in Medicare or Medicaid; whose license to issue prescriptions has been revoked or suspended by any state licensing board; or whose prescribing habits have been determined by BCBSM to deviate significantly from established standards of medical necessity.

Screening Services
Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.

Secondary Plan
The health care plan obligated to pay for services after the primary plan has paid for services.

Self-Dialysis Training
Teaching a member to conduct dialysis on himself or herself.

Semiprivate Room
A hospital room with two beds.

Service Area
The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

NOTE: BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.

Services
Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.

Skilled Care
A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:

- Ordered by the attending physician
- Medically necessary according to generally accepted standards of medical practice
- Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician.

Skilled Nursing Facility
A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Small Bowel Transplant
A procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver.

Special Medical Foods
Special foods that are formulated for the dietary treatment of inborn errors of metabolism. The nutritional requirements of the patient are established by a physician's medical evaluation of the patient. The diet must be administered under the supervision of a physician.

Specialist
A provider with a specific skill or expertise in the treatment of a particular condition or disease. The patient is referred to a specialist by his or her PCP.

Specialty Hospitals
Hospitals that treat specific diseases, such as mental illness.

Specialty Pharmaceuticals
Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer but excludes injectable insulin. **Select specialty pharmaceuticals require prior authorization from BCBSM.**

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by infusion therapy providers
- Drugs administered in the office by health care practitioners
  Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

NOTE: BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

Specialty Pharmacy
Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech and Language Pathology Services
Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Spouse
An individual who is legally married to the subscriber and meets the group's eligibility requirements.

Stabilize
Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child (including the placenta)).

Stem Cells
Primitive blood cells originating in the marrow, but also found in small quantities in the blood.

These cells develop into mature blood components including red cells, white cells and platelets.

Subrogation
Subrogation occurs when BCBSM or the Plan assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

Subscriber
The person who signed and submitted the application for coverage.

Substance Abuse Treatment Program Services
Subacute services to restore a person's mental and physical well-being when the person has a substance use disorder. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

Substance Use Disorder
Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being
- Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior
- Endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Substance use disorder is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases."

NOTE: Tobacco addictions are included in this definition.

Syngeneic Transplant
A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.

Tandem Transplant
A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and if the patient's cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.

T-Cell Depleted Infusion
A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Technical Surgical Assistance
Professional active assistance given to the operating physician during surgery by another physician not in charge of the case.

NOTE: Professional active assistance requires direct physical contact with the patient.

Terminally Ill
A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

Termination
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

Therapeutic Shoes
Therapeutic or diabetic shoes are prescribed by a physician or certified nurse practitioner and are either "off-the-shelf" or custom-molded shoes which assist in protecting the diabetic foot.

Total Body Irradiation
A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

Treatment Plan
A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered because of the member's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member's physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

Urgent Care
Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or professional providers' offices.

Valid Application
An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.

Voluntary Sterilization
Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

Waiting Period
Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.

Ward
A hospital room with three or more beds.

We, Us, Our
Used within BCBSM's certificates and riders when referring to Blue Cross Blue Shield of Michigan.

Well-Baby Care
Services provided in a physician's office to monitor the health and growth of a healthy child.

Working Aged
Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse's current employment.

Working Disabled
Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.

You and Your
Used when referring to any person covered under this Plan.

SECTION 4 — PRESCRIPTION DRUG BENEFITS

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitation and exclusions may apply. Payment amounts are based on the Blue Cross Blue Shield of Michigan (BCBSM) approved amount, less any deductible/coinsurance/copayment that may be required. For a detailed description of benefits, please see the applicable BCBSM certificates, riders and plan modifications (called the Plan Documents). If there is a discrepancy between this benefit summary and Plan Documents, the Plan Documents will control.

EXPRESS SCRIPTS®

Express Scripts® is an independent company providing pharmacy benefit services for BCBSM participants and their family. Your BCBSM ID card identifies that you have a prescription drug program. For information, assistance, mail order forms, etc., access BCBSM's web site at www.bcbsm.com/pharmacy or call the number on the back of your BCBSM ID card.

Prescription Drugs Day Supply
Your pharmacy program allows for a thirty (30) day supply of a covered prescription drug. BCBSM may make exceptions for prescription drugs whose minimal package size prevents a thirty (30) day supply from being dispensed.

Ninety (90) Day Mail Order and Retail Prescription Drug Program
In addition to a thirty (30) day supply for a prescription, your plan allows for a ninety (90) day supply through either your BCBSM ninety (90) day retail pharmacy program or ninety (90) day mail order program for **non-specialty** drugs (see additional information on **specialty** drugs below.) Your physician **must** write your prescription for ninety (90) days.

Specialty Pharmaceutical Drugs
Select specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration and monitoring. Most "**In-network**" retail pharmacies can dispense specialty drugs. You should, however, check with your local pharmacy for availability and assistance.

BCBSM will **not** pay for more than a thirty (30) day supply of a covered prescription drug that BCBSM defines as a "**specialty pharmaceutical drug**" even if the drug is obtained from a ninety (90) day retail network pharmacy or mail-order provider. BCBSM may make exceptions if a member requires more than a thirty (30) day supply.

BCBSM also reserves the right to limit the quantity for certain select specialty drugs to no more than a fifteen (15) day supply for an initial fill. Any applicable copayment/coinsurance will be reduced by one-half (1/2) for a prescription that has been reduced to a fifteen (15) day supply. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable copayment/coinsurance requirement for a thirty (30) day) supply.

Walgreens Specialty Pharmacy, LLC (an independent company) is also available to assist for **mail order** prescriptions for **specialty pharmaceutical drugs**. If you have questions, or require assistance, call Walgreens Specialty Pharmacy customer service at **866-515-1355**. Note that

Walgreens Specialty Pharmacy provides mail order services **only for specialty drugs**. Other mail order prescriptions should be sent to Express Scripts®.

Controlled Substance Prescription Drugs
BCBSM may limit the initial fill of a select controlled substance prescription drug (such as hydromorphone, oxycodone, etc.) to a five (5) day supply. You will be responsible for your applicable copayment/coinsurance or the cost of the prescription drug, whichever is lower, for the five (5) day supply. The remaining twenty-five (25) day supply can be refilled (if needed) after the initial five (5) day) supply. You will be responsible for your copayment/coinsurance or the cost of the prescription drug, whichever is lower, for the remaining twenty-five (25) day supply. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable copayment/coinsurance requirement for a thirty-day (30-day). A list of select controlled substance prescriptions affected by this requirement are available online at www.bcbsm.com/pharmacy.

Note: BCBSM will not pay for prescription drugs obtained from an out-of-network mail order provider, including internet providers.

MEMBER'S RESPONSIBILITY (COPAYMENT AMOUNTS)

Note: The following amounts will not apply to your medical deductible and/or coinsurance annual maximums or out-of-pocket maximum if applicable.

- Copayments (including mail order copayment amounts)
- Any difference between the Maximum Allowable Cost and the BCBSM approved amount for a covered brand name drug that is your responsibility
- The twenty-five percent (25%) member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-Day retail network pharmacy	In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic Drugs	1-30 day supply	**$10** copayment	**$10** copayment	**$10** copayment	**$10** copayment plus an additional **25%** of the approved amount
	31-83 day supply	No coverage	**$20** copayment	No coverage	No coverage
	84-90 day period	**$20** copayment	**$20** copayment	No coverage	No coverage
Brand Name Drugs	1-30 day supply	**$40** copayment	**$40** copayment	**$40** copayment	**$40** copayment plus an additional **25%** of the approved amount
	31-83 day supply	No coverage	**$80** copayment	No coverage	No coverage
	84-90 day supply	**$80** copayment	**$80** copayment	No coverage	No coverage

Covered Services				
Benefits	**90-Day retail network pharmacy**	**In-network mail order provider**	**In-network pharmacy (not part of the 90-day retail network)**	**Out-of-network pharmacy**
Prescribed over-the-counter drugs when covered by BCBSM	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**75%** of the approved amount less plan copayment
FDA-approved drugs when covered by BCBSM	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**75%** of the approved amount less plan copayment
State-controlled drugs when covered by BCBSM	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**75%** of the approved amount less plan copayment
FDA-approved **generic** and **select brand-name** prescription preventive drugs and supplements when covered by BCBSM	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**75%** of the approved amount less plan copayment
FDA-approved **generic** and **brand name** prescription contraceptive medications (non-self-administered drugs are not covered)	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**100%** of the approved amount less plan copayment	**75%** of the approved amount less plan copayment
Insulin or other covered injectable legend drugs dispensed with disposable needles and syringes **Note:** Needles and syringes do not require a separate copayment or coinsurance	**100%** of the approved amount less plan copayment for insulin or other covered injectable legend drug	**100%** of the approved amount less plan copayment for insulin or other covered injectable legend drug	**100%** of the approved amount less plan copayment for insulin or other covered injectable legend drug	**75%** of the approved amount less plan copayment for insulin or other covered injectable legend drug

Features of your Prescription Drug Plan	
Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by BCBSM for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost • Generic Drugs - includes most generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as many brand-name drugs. These drugs require the lowest copayment making them the most cost-effective option for the treatment. • Brand Name Drugs – includes brand name and specialty drugs. These drugs require a higher copayment.
Prior Authorization/Step Therapy	Prior Authorization is a process that requires a physician to obtain approval from BCBSM before select prescription drugs (as identified by BCBSM) will be covered. Step therapy, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. Details about which drugs require prior authorization or step therapy are available online at www.bcbsm.com/pharmacy.
Maximum Allowable Cost (MAC) Drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, **you will be required** to pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug (plus your applicable copayment) for which a generic equivalent is available unless your physician writes "Dispense as Written" or "DAW" on your prescription. If "DAW" is written on your prescription, BCBSM will pay the approved amount less your copayment. **Note**: The MAC difference will not be applied toward any annual deductible, annual coinsurance maximum or annual out-of-pocket maximum.
Quantity limits for selected drugs	BCBSM may limit the quantity of select medications. These limits are consistent with FDA approved dosing guidelines.
Brand-to-Generic Interchange and Copayment/Coinsurance Waiver Program	BCBSM's drug interchange and generic copayment/coinsurance waiver program encourages physicians to prescribe less-costly generic equivalent drugs. If your physician rewrites your prescription for the recommended generic or over-the-counter (OTC) alternate drug, you will only have to pay the applicable generic copayment/coinsurance percentage. In select cases, BCBSM may waive the initial copayment/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Off-label/ High-cost specialty review programs	BCBSM's specialty review program does not allow coverage for drugs prescribed for uses other than those approved by the Federal Drug Administration (FDA). This program requires a prior authorization review of high cost specialty drugs.
Dose optimization	BCBSM may discuss with your physician the use of specific prescription drugs in once-daily dosage regimens as opposed to using lower multiple doses of the same drug.

***Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. A prescription for an OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

LIMITATIONS AND EXCLUSIONS

Note: The following is a list of common limitations and exclusions that may apply to your benefit plan. This list is not all inclusive. Additional limitations and exclusions may apply and can be found in your applicable BCBSM certificate, riders and plan modifications.

- Therapeutic devices or appliances, including but not limited to, hypodermic or disposable needles and syringes when not dispensed with a covered injectable drug, insulin or self-administered chemotherapeutic drugs.
- Prescription drugs prescribed for cosmetic purposes.
- The charge for any prescription refill in excess of the number specified by the prescriber or any refill dispensed one year after the prescriber's prescription order.
- Administration of covered drugs; e.g., injections.
- Non-self-administered injectable drugs (except for select immunization vaccines).
- Any vaccine given solely to resist infectious diseases.
- More than a thirty-day (30-day) supply of a covered drug. Exceptions may be made for certain maintenance drugs, for drugs whose minimal package size prevents a thirty-day (30-day) supply from being dispensed; e.g., inhalers or drugs approved through a ninety-day (90-day) retail or mail order program.
- More than a thirty-day (30-day) supply of specialty drugs even if obtained through a ninety-day (90-day) retail or mail order program.
- More than the quantities and doses allowed per prescription of select drugs unless the prescribing physician obtains preauthorization from BCBSM.
- More than twelve (12) doses of an impotence drug in a thirty (30) day period.
- Any drug determined to be experimental or investigational by BCBSM.
- Any covered drug entirely consumed at the time and place of the prescription.
- Anything other than a covered drug or service that is a pharmaceutical benefit.
- Administration of covered drugs; e.g., injections.
- Non-self-administered contraceptive drugs or devices.
- Diagnostic agents.

- Any drug or device prescribed for uses or in doses other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off-label use of a drug or device. Some chemotherapeutic drugs may be subject to prior authorization review.

- Select chemotherapy specialty pharmaceuticals that are not preauthorized.

- Drugs that are not labeled FDA-approved, except for state-controlled drugs and insulin or such drugs that BCBSM designates as covered.

- Drugs newly approved by the FDA and not yet reviewed for coverage determination by BCBSM.

- Drugs not recommended and/or approved by BCBSM.

- Drugs that would be covered as a Medical benefit under a BCBSM medical certificate.

- Drugs or services obtained before the effective date of this contract or after this contract ends.

- Non-preferred co-branded drugs unless they are preauthorized by BCBSM.

- Costs for covered drugs or services submitted after the applicable time limit for filing a claim.

- Support garments or other non-medical items.

- Any contraceptive medications and devices, whether over-the-counter or FDA-approved or not, regardless of the reason they were prescribed or their intended use other than noted as a covered benefit.

- Compound drugs that contain any bulk chemical powders that are not approved by BCBSM.

- Prescription drug services for the treatment of gender dysphoria that are considered by BCBSM to be cosmetic or prescription drug treatment that is experimental or investigational.

- Compound hormones.

- Refills of prescriptions for covered drugs that exceed BCBSM's limits; i.e., refills before seventy-five percent (75%) of the time period the prescription covers has elapsed; i.e., thirty-day (30-day) prescription can be refilled after the twenty-three (23) days.

- More refills than the prescription allows.

- Drugs that do not meet prior authorization requirements, cannot be split into short fill periods, or do not meet quantity limits or dose optimization criteria established by BCBSM.

DEFINITIONS

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Adverse Benefit Decision
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

Approved Amount
The lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug. The drug cost, dispensing fee and incentive fee are set according to our contracts with pharmacies. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments or coinsurances that may be required of you are subtracted from the approved amount before we make our payment.

BCBSM
Blue Cross Blue Shield of Michigan.

Cancellation
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

Certificate
This book, which describes your benefit plan, and any riders that amend it.

Clinical Trial
A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, clinical trials include:

- Phase II - a study conducted on a larger number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment
- Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coinsurance
A portion of the approved amount that you must pay for a covered drug. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by an audit, adjustment, or recovery. For prescription drugs, your coinsurance is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A Federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends,
- You lose coverage as a dependent of the covered employee, or
- Another qualifying event.

If you elect COBRA coverage, you pay 100 percent of the premiums, including the share the employer used to pay for you plus a small administrative fee.

Contraceptive Medication
A medication intended to prevent pregnancy.

Contract
This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Conventional Treatment
Treatment that has been scientifically demonstrated to be safe and effective for treatment of the patient's condition.

Copayment
The dollar amount that you must pay for a covered drug. Your copayment is not altered by any audit, adjustment, or recovery. For prescription drugs, your copayment is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

NOTE: A separate copayment is not required for covered disposable needles and syringes when dispensed at the same time as insulin or chemotherapeutic drugs.

Your copayment will be reduced by one-half (1/2) for the initial fill (15 days) of select specialty drugs once applicable deductible(s) have been met.

Cosmetic Drugs
Prescription drugs that are used primarily for improving appearance rather than for treating a disease.

Covered Drugs
A FDA-approved drug, or such drugs that BCBSM designates as covered, if the following conditions are met:

- A prescription must be issued by a prescriber who is legally authorized to prescribe drugs for human use.

- The cost of the drug must not be included in the charge for other services or supplies provided to you.

- The drug is not entirely consumed at the time and place where the prescription is written.

- The drug must also be approved by the Federal Food and Drug Administration for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by one of the following sources:

- The American Hospital Formulary Service Drug Information

- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"

- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

NOTE: Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of this certificate.

"DAW" (Dispense as Written)
An instruction on a drug prescription by a prescriber that requires the pharmacist to dispense only the drug named on the prescription.

Deductible
The amount that you must pay for covered drugs, under any certificate, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time of the claims are processed. Your deductible is not altered by an audit, adjustment, or recovery. For prescription drugs, your deductible is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.

Diagnostic Agents
Substances used to diagnose rather than treat a condition or disease.

Dispensing Fee
The amount we pay to a provider for filling a prescription.

Drug List
A list of approved drugs, as determined by a group of physicians, pharmacists and other experts that review drugs for coverage determination.

Effective Date
The date your coverage begins under this contract. This date is established by BCBSM.

Elective Abortion
The intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman.

Eligible Drug
An eligible drug is a brand name version of one of the prescription drugs that the Federal government requires this plan to cover but it has not been prior authorized by BCBSM and is not payable by BCBSM. To qualify as an eligible drug, all the following requirements must be met:

- A prescription for the drug must be issued by a prescriber who is legally authorized to prescribe drugs for human use.
- The cost of the drug must not be included in the charge for other services or supplies provided to you.
- The drug is not entirely consumed at the time and place where the prescription is written.

The drug must also be approved by the Federal Food and Drug Administration for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by one of the following sources:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

NOTE: Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of this certificate.

Emergency Pharmacy Services
Drugs needed immediately because an injury or illness occurred suddenly and unexpectedly.

Exigent Circumstance
An exigent circumstance exists when you suffer from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a drug that is not on our approved drug list.

Experimental Treatment
Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."

First Priority Security Interest
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Food and Drug Administration (FDA)
An agency within the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

Gender Dysphoria
A broad diagnosis that covers a person's emotional discontent with the gender they were assigned at birth. A clinical diagnosis is made when a person meets the specific criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Gender Reassignment Services
A collection of drugs that are used to treat gender dysphoria. These services may include hormone treatment. They must be medically necessary to be payable by BCBSM. BCBSM will not pay for drugs that it considers to be cosmetic. BCBSM will also not pay for drugs that are experimental or investigational.

Generic Equivalent
A prescription drug that contains the same active ingredients, is identical in strength and dosage form and is administered in the same way as the brand name drug.

Group
A collection of members under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

High Abuse Drugs
Drugs that affect the central nervous system and cause sedation, euphoria, or mood change.

In-Network Mail-Order Provider
A provider selected by BCBSM to provide covered drugs through our PPO program. In-network mail-order providers have agreed to accept the approved amount as payment in full for the covered drugs provided to members enrolled in BCBSM's PPO mail-order program.

In-Network Pharmacy
A provider selected by BCBSM to provide covered drugs through BCBSM's PPO program. In-network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to members.

Lien
A first priority security interest in any money or other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

Life-threatening Condition
Any disease or condition from which the likelihood of death is probable unless the course of the disease of condition is interrupted.

Maximum Allowable Cost (MAC)
The most BCBSM will pay for certain covered drugs we have identified under the Maximum Allowable Cost Program.

Maximum Allowable Cost Drugs
Certain generically equivalent drugs BCBSM has identified under the Maximum Allowable Cost Program.

Maximum Allowable Cost Program
A BCBSM cost containment program that encourages the use of generic drugs. The MAC Program places a cost limit on certain drugs for which a generically equivalent drug is available at a lower cost.

Medically Necessary
A drug must be medically necessary to be covered, as determined by pharmacists and physicians acting for BCBSM, based on criteria and guidelines developed by pharmacists and physicians for BCBSM. The covered drug must be accepted as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or prescriber.

In the absence of established criteria, medical necessity will be determined by pharmacists and physicians according to accepted standards and practices.

Medication Synchronization
A coordination process which allows you, your prescriber, and your pharmacist to synchronize your multiple maintenance prescription drugs. You, and the drugs you take, must meet specific requirements in order to synchronize your medication.

Member
Any person eligible for drugs under this certificate on the date they are rendered. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered drugs.

Multiple Source Brand (MSB) Drug
A brand-name drug that has a generic equivalent available.

Nonpreferred Brand-Name Drug
A nonpreferred brand-name drug that is on BCBSM's drug list.

Off-Label
The use of a drug or device for clinical indications other than those stated in the labeling approved by the Federal Food and Drug Administration.

Out-of-Network Pharmacy
A provider that has not been selected for participation and has not signed an agreement to provide covered drugs through BCBSM's PPO program. Out-of-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs provided to members.

Participating Providers
Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Any cost-share, which may be required of you, is subtracted from the approved amount before BCBSM makes a payment.

Patient
The subscriber or eligible dependent who is awaiting or receiving covered drugs.

Pay-Provider Claim
This is a type of claim where Blue Cross pays your provider directly according to the terms of your coverage.

Pay-Subscriber Claim
This is a type of claim where Blue Cross will reimburse you, the subscriber, according to the terms of your coverage. Either you or your provider may submit this type of claim.

Pharmacy
A licensed establishment where a licensed pharmacist dispenses prescription drugs under the laws of the state or country where the pharmacist practices.

Physician
A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners."

Plaintiff
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Post-service Grievance
A post-service grievance is an appeal that you file when you disagree with BCBSM's payment decision or BCBSM's denial for a service that you have already received.

Preferred Brand-Name Drug
A preferred brand-name drug that is on BCBSM's drug list.

Preferred Provider Organization (PPO)
A limited group of pharmacies that have been selected for this program and have agreed to provide covered drugs or services to BCBSM members and accept the approved amount as payment in full.

Prescriber
A health care professional authorized by law to prescribe FDA-approved or state-approved drugs for the treatment of human conditions.

Prescription
An order for medication or supplies written by a prescriber, as defined in this section.

Pre-service Grievance
A pre-service grievance is an appeal that you can file when you disagree with BCBSM's decision not to pre-approve a service you have not yet received.

Prior Authorization
Some prescription drugs require prior authorization before you receive them. If you receive them without first obtaining prior authorization, you may have to pay the bill yourself. BCBSM may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive these drugs.

Provider
A pharmacy legally licensed to dispense drugs.

Qualified Individual
An individual eligible for coverage under this certificate who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

- The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol, or
- The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols.

Qualifying Beneficiary
Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualifying Event
One of the following events that allows you to enroll in different health care coverage or change your current coverage or allows a beneficiary to receive coverage under COBRA:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Start of Military Service--Employees must perform military duty for 31 or more days
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

NOTE: The examples in this definition are not exhaustive and may change. Please call Customer Service for more information about qualifying events.

Registered Provider
A participating or nonparticipating provider that is an in-network or out-of-network PPO provider that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Remitting Agent
Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber
- Pay the subscriber's BCBSM bill

Rescission
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

Rider
A document that amends this certificate by adding, limiting, deleting or clarifying benefits.

Right of Recovery
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Routine Patient Costs
All items and drugs related to an approved clinical trial if they are covered under this certificate (or any riders that amend it) for members who are not participants in an approved clinical trial. They do not include:

- The investigational item, device, or drugs itself
- Items and drugs provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or
- A drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sanctioned Prescriber
Any provider who has been disciplined under Section 1128 and Section 1902(a) (39) of the Social Security Act; excluded or suspended from participation in Medicare or Medicaid; whose license to issue prescriptions has been revoked or suspended by any state licensing board; or whose prescribing habits have been determined by BCBSM to deviate significantly from established standards of medical necessity.

Select Controlled Substances
Specific medications identified by BCBSM as requiring limits on the quantity dispensed or the day supply. These medications are regulated by state and/or federal laws that aim to control the danger of addiction, overuse, physical and mental harm, death, trafficking by illegal means**,** and other harms. A list of these medications is available at bcbsm.com/pharmacy.

Select Over-the-Counter Drugs
Over-the-counter drugs identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's prescriber. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Select Prescription Drugs Requiring Prior Authorization
Prescription drugs identified by BCBSM as requiring prior authorization. A description of the drugs and the criteria for approval are provided in a list that is updated periodically by BCBSM.

Your prescriber or pharmacist can call BCBSM for this list. Select prescription drugs do not include antineoplastic drugs or drugs needed to treat an immediate life-threatening condition.

Short Fill Period
A shorter prescription drug fill time period. For example, a normal fill for your prescription could be 30 days. A short fill period would be to fill your prescription for 15 days. This short fill period is used to synchronize medications or to avoid waste when trying new medications.

Specialty Pharmaceuticals
Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include chemotherapy drugs used in the treatment of cancer but excludes injectable insulin. **Select specialty pharmaceuticals require prior authorization from BCBSM.**

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by home infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

NOTE: BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

Specialty Pharmacy
Companies that specialize in specialty medications and the associated clinical management support.

Spouse
An individual who is legally married to the subscriber and meets the group's eligibility requirements.

State-Controlled Drugs
Drugs that are usually sold over-the-counter but require a prescription under state law when certain quantities are dispensed.

Step Therapy
Previous treatment with one or more preferred drugs may be required.

Subrogation
Subrogation occurs when BCBSM or the Plan assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

Subscriber
The person who signed and submitted the application for coverage.

Termination
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

We, Us, Our
Used when referring to Blue Cross Blue Shield of Michigan in their certificate.

You and Your
Used when referring to any person covered under this Plan.

SECTION 5 — CLAIMS AND APPEALS PROCESS

YOUR RIGHT TO REQUEST REVIEW OF AN ADVERSE BENEFIT DETERMINATION

Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved through a phone call to one of BCBSM's Customer Service Representatives. You can locate the phone number on the back of your ID card, on the top right-hand corner of the first page of your Explanation of Benefits statement or in the letter BCBSM sends to notify you that BCBSM has not approved a request for benefits. The following ERISA claims procedures are not applicable to any other benefit contained in this SPD. Claims and appeals procedures for other benefits are located within those sections.

ERISA's claims procedure rules protect you by providing you the opportunity to request review of an adverse benefit determination. No legal action may be initiated against the Plan, the Plan Administrator or the Fund Trustees regarding a claim for benefits or eligibility under the Plan or regarding any interpretation or administration of the Plan until you have followed and exhausted the Plan's Claims and Appeals Procedures.

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in the Plan. An adverse benefit determination also includes a rescission of coverage. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

"Pre-service claim"
"Pre-service Claim" means a claim for a benefit where the Plan conditions receipt of the benefit, in whole or in part, on obtaining approval in advance of receiving medical care.

"Urgent care claim"
"Urgent care claim" means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function. An urgent care claim can also be made when, or in the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care if a physician with knowledge of your medical condition determines the claim is one involving urgent care. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, BCBSM will treat it as such. Absent a determination by your physician, BCBSM will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

"Post-service claim"
"Post-service claim" means all other claims that are not "pre-service claims" or "urgent care claims."

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing.

REVIEW PROCEDURES – POST-SERVICE CLAIMS

Appeal to BCBSM – Level 1

Under the review procedure for post-service claims, you are entitled to a two-step appeal process. In the first step, BCBSM will provide you with a written determination within sixty (60) calendar days of BCBSM's receipt of your written request for review.
The review procedure for post-service claims allows the following:

Level 1 -- to initiate an internal review, you or your authorized representative must send BCBSM a written statement explaining why you disagree with their determination. Please include in your request all documentation, records or comments you believe support your position. You can also include notarized statements, declarations or testimony but these are not required. You must request review no later than one hundred eighty (180) calendar days after you receive BCBSM's decision on your claim for benefits. You may access a Member Appeal form from the BCBSM website www.bcbsm.com/memberappeal.

Mail your written request for review to:

DOL/ERISA Appeals
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd., Mail Code 1620
Detroit, MI 48226

or

to the address contained in a letter that BCBSM may send you to notify you that BCBSM has not approved a benefit or service you are requesting.

BCBSM will respond to your request for review in writing within sixty (60) days of the date BCBSM received your original written appeal. If you agree with BCBSM's response, this becomes their final determination and the review ends.

If you disagree with BCBSM's final determination, or if BCBSM fails to provide a final determination within sixty (60) days of the date that BCBSM receives your original written appeal, you may appeal to the Board of Trustees.

Appeal to Board of Trustees – Level 2

If BCBSM denies your appeal and you disagree with the decision at Level 1, you may appeal directly to the Plan's Board of Trustees. You must request a review, in writing, within sixty (60) days of the date you receive BCBSM's Level 1 decision. You should mail your request to the address specified in BCBSM's letter that denied your claim or directly to:

UWUA Health & Welfare Plan Appeals Department
6525 Centurion Drive
Lansing, MI 48917-9275
517-321-7502 or 800-920-8116

Your appeal to the Board of Trustees should include a copy of BCBSM's Level 1 denial letter. You should also include documents, records and comments that you think support your claim. You should include these documents even if you already provided them to BCBSM. The Trustees will generally decide your Level 2 appeal at the Plan's next quarterly scheduled Board of Trustees meeting, unless your request for review is filed within 30 days preceding the date of that meeting. In that instance, the review may be held no later than the second quarterly meeting following your request for review. The benefit determination will be made at the meeting and you will be notified not later than five (5) days after the determination is made.

If you disagree with the final determination of your Level 2 appeal, or if you fail to receive a final determination, or otherwise fail to receive a reply that complies with the review procedures, you have the option to bring a civil action under Section 502(a) of ERISA to obtain your benefits.

REVIEW PROCEDURE – PRE-SERVICE CLAIMS

1. The appeals procedure for pre-service claims follows the same procedure for post-service claims, except that you must be provided with a written determination within a shorter time frame. A determination will be issued by BCBSM within fifteen (15) calendar days of receipt of your request for a level one (1) review. You still have sixty (60) days after receipt of the level one (1) determination to file your level two (2) appeal. Your initial appeal must be requested within sixty (60) days of the date your received notice that your services was not approved.

2. If you disagree with the final determination, or if the determination at each level is not issued within the fifteen (15) day time frame or the review procedures for level one (1) or level two (2) are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

Pre-service Appeal Addresses for Select Services For Specified Organ or Bone Marrow Transplants:

Human Organ Transplant Program
BCBSM
600 E. Lafayette Blvd., Mail Code 504C
Detroit, MI 48226
FAX: 866-752-5769

For Inpatient Admissions to Hospitals, Skilled Nursing Facilities or Acute Rehabilitation Facility:

Precertification Medical Records and Appeals
BCBSM
P.O. Box 321095, Mail Code 511B
Detroit, MI 48232-1095
FAX: 877-261-4555

For Case Management Services:

Case Management Program
BCBSM
600 E. Lafayette Blvd., Mail Code 504A
Detroit, MI 48226-2998
FAX: 866-643-7057

For Prescriptions Drugs:

Pharmacy Services
BCBSM
P.O. Box 2320
Detroit, MI 48231-232
FAX: 866-915-9187

For Medical Specialty Drugs:

Blue Cross Blue Shield of Michigan
Specialty Pharmacy Appeals
P.O. Box 312320
Detroit, MI 48231-2320
FAX: 866-915-9187

REVIEW PROCEDURE – URGENT CARE CLAIMS

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call the BCBSM customer service number on the back of your ID card for assistance.

2. You or your authorized representative may file a request for an urgent care internal appeal if you believe that BCBSM has wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service, or if BCBSM failed to respond in a timely manner to a request for a benefit or payment.

3. BCBSM must provide you with their decision as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of your request for review. All necessary information, including BCBSM's decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If BCBSM's decision is communicated orally, BCBSM must provide you or your authorized representative with written confirmation of BCBSM's decision within two (2) business days.

4. You may appeal to the Board of Trustees an urgent care claim that has been denied by BCBSM. Your request must be submitted within ten (10) days of your receipt of BCBSM's denial, termination or reduction in coverage for a health care service. Contact the UWUA Fund Office, Urgent Care Claims Appeals Department, 800-920-8116 or 517-321-7502; or Fax 517-321-7508.

5. If you disagree with the final determination, or if you fail to receive a final determination within seventy-two (72) hours, or otherwise fail to receive a reply that complies with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

6. In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims:

   a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure.

   b. No fees or costs may be imposed as a condition to requesting review.

   c. Although there are set timeframes within which you must receive BCBSM's final determination on all three types of claims, you have the right to allow BCBSM (and/or the Board of Trustees) additional time if you wish.

   d. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

   e. You may submit notarized statements, written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.

   f. The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.

   g. If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.

   h. Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.

i. On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.

j. If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion without charge upon request.

k. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment without charge upon request.

SECTION 6 — COBRA CONTINUATION COVERAGE

This section is intended to explain to you, your spouse and your eligible dependents, in a summary fashion, about *rights and obligations* under the health care continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or "COBRA." You, your spouse (if any), and your dependents (if any) should take time to read this section carefully.

DEFINITIONS

COBRA Costs
The COBRA rate, the cost to you, is determined annually. Contact the Fund Office for questions about the amount.

Continuation Coverage
The coverage available to you, your spouse and/or eligible dependents in the event you lose eligibility due to a Qualifying Event. If you elect Continuation Coverage, the Plan must provide coverage which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries for basic hospital, medical, and surgical benefits.

Qualified Beneficiary
An individual who is covered under the Plan on the day before a Qualifying Event, as well as a newborn child or child placed for adoption with you during the period of Continuation Coverage. Qualified Beneficiaries are you, your spouse and/or your eligible dependent child(ren).

Qualifying Event
An event that causes you and/or one or more eligible members of your family to lose coverage under the Plan. The specific events which are Qualifying Events for you, your spouse and/or your eligible children are explained in detail in the following sections. Depending on the Qualifying Event, Continuation Coverage is available for up to eighteen (18), twenty-nine (29) or thirty-six (36) months.

Employee Right to Elect Continuation Coverage
You, as a Qualified Beneficiary, have the right to choose health care Continuation Coverage if you lose eligibility for coverage under the Plan:

- due to a reduction in the amount of employer contributions remitted;
- termination of employment for any reason, unless termination is due to gross misconduct on your part; or
- Start of military service if you perform military duty for thirty-one (31) or more days.

Each of these circumstances is what is known as a "Qualifying Event" for you, as an employee. These Qualifying Events entitle you and/or your family to elect up to eighteen (18) months of Continuation Coverage.

The Trustees, through the Fund Office, determine when a Qualifying Event occurs as a result of a reduction of employer contributions or a termination of employment based on information included on submitted employer contribution forms. The Fund Office will determine when the Qualifying Event has occurred within one hundred twenty (120) days following receipt of the employer contribution form. The Fund Office will mail a COBRA election notice within sixty (60) days after it has determined that you or a Qualified Beneficiary has lost eligibility for

coverage. You have sixty (60) days from the date you receive the election notice to elect Continuation Coverage. If you do not make an election for coverage within sixty (60) days, you no longer have a right to elect to receive Continuation Coverage.

If you qualify for Continuation Coverage under COBRA but do not elect such coverage for your entire family, your spouse and/or dependent children are still entitled to elect Continuation Coverage for themselves as long as their election is made within the same election period in which you qualify.

Your Spouse's Right to Elect Continuation Coverage
Spouses of employees covered under the Plan, as Qualified Beneficiaries, have the right to choose Continuation Coverage for themselves if they lose their group health care coverage under the Plan for any of the following reasons:

- Termination of your employment (for reasons other than gross misconduct), or a reduction in the hours worked by you which results in your losing eligibility under the Fund;
- Your death;
- Divorce or legal separation from you; or
- You become entitled to Medicare and are not eligible to continue coverage for your spouse under another portion of the Plan or choose not to continue such coverage.

These reasons are known as Qualifying Events for your spouse. The first Qualifying Event entitles your spouse to elect up to eighteen (18) months of Continuation Coverage. The other Qualifying Events entitle your spouse to elect up to thirty-six (36) months of Continuation Coverage.

Your Dependent Children's Right to Elect Continuation Coverage
Your dependent children covered under the Plan, as Qualified Beneficiaries, have the right to elect Continuation Coverage if they lose their eligibility for coverage under the Plan for any of the following reasons:

- Termination of covered employee's employment (for reasons other than gross misconduct) or a reduction in the number of hours worked by the parent who is the covered employee under the Plan;
- Death of the parent, who is the covered employee under the Plan:
- Divorce or legal separation of the parents – at least one of whom remains covered under the Plan;
- You become entitled to Medicare and either are not eligible to continue coverage for the children or choose not to continue such coverage; or
- The child or children cease to satisfy the Plan's definition of a "dependent child."

These reasons are known as Qualifying Events for your dependent children. The first Qualifying Event entitles your dependent children to elect up to eighteen (18) months of Continuation Coverage. The other Qualifying Events entitle your dependent children to elect up to thirty-six (36) months of Continuation Coverage.

A newborn or adopted child will automatically be extended COBRA coverage if the parents already have COBRA coverage. But, this may involve an increase in the COBRA premium charged. A newborn child or an adopted child (or the child's custodian or guardian) has a right,

separate from his or her parents, to elect Continuation Coverage for up to eighteen (18) or thirty-six (36) months, depending on the Qualifying Event, even if the child's parent(s) do not elect Continuation Coverage.

Continuation Coverage for Disabled Persons

If you, as a covered Employee, your spouse, or any dependent children, as Qualified Beneficiaries, qualify for Social Security disability benefits at the time of a Qualifying Event that entitles the Qualified Beneficiary to elect eighteen (18) months of Continuation Coverage (or any time during the first sixty (60) days after you lose coverage due to a Qualifying Event), you may purchase up to an additional eleven (11) months of Continuation Coverage (or a total of up to twenty-nine (29) months).

This additional Continuation Coverage may be purchased not only for the disabled person but also for other family members who are not disabled (subject to the payment of the applicable premium).

To obtain this additional Continuation Coverage, the Qualified Beneficiary must be determined eligible for Social Security disability benefits before the end of the eighteen (18) month Continuation Coverage period and must notify the Fund Office during the eighteen (18) month period and within sixty (60) days after the Social Security Administration awards Social Security benefits to the disabled person.

The Fund is permitted to charge a higher premium (up to one-hundred fifty percent (150%) of the regular COBRA premium) for up to eleven (11) additional months of Continuation Coverage available to disabled persons and their families. The higher premium applies to the disabled person and to other non-disabled family members who opt for this additional COBRA coverage.

Eligibility for extended Continuation Coverage because of disability ends the first day of the month that is more than thirty (30) days after the date that the once disabled person is determined by the Social Security Administration to be no longer disabled. Federal law requires a disabled person to notify the Fund within thirty (30) days of a final Social Security Administration determination that he or she is no longer disabled.

Employee Obligations to Notify the Fund Office of a Qualifying Event

Under COBRA, you or a family member must notify the Fund Office within sixty (60) days about a divorce, legal separation, or a child losing dependent status under the Plan. If such an event is not reported to the Fund Office within sixty (60) days after it occurs, Continuation Coverage will not be permitted.

Your surviving spouse (or dependent child) should contact the Fund Office immediately after your death. This assures that Continuation Coverage is offered to your surviving spouse and children at the earliest possible date.

The law requires the COBRA election notice to be sent to the last known address on file at the Fund Office. If the election notice is sent to the wrong address due to your failure to notify the Fund Office about a change in address, the sixty (60) day time limit will not be extended and you may lose the opportunity to elect COBRA Continuation Coverage.

You are also required to notify the Fund Office if you or any family members are covered under another group health care plan at the time you received a COBRA election notice (*e.g.,* if you are

covered as a dependent under your spouse's plan) or, if at any time you or a family member later becomes covered under another group health care plan, including Medicare.

The Fund Office may require you to provide information about your coverage under another group health care plan. The Fund may seek reimbursement directly from you if medical expenses are paid by the Utility Workers' Union of America National Health & Welfare Plan because you or your dependents do not notify the Fund of other health care coverage.

Second Qualifying Events

The following rules concerning the occurrence of a second Qualifying Event only apply if the original Qualifying Event was termination of the employee's employment (for reasons other than gross misconduct) or reduction in the number of hours worked by the employee. If a second Qualifying Event should occur during the eighteen (18) months of coverage available as a result of the first Qualifying Event [or, up to twenty-nine (29) months if the eleven (11) month extension due to disability applies], then you may purchase additional Continuation Coverage for up to a total of thirty-six (36) months. An example of a second Qualifying Event would be:

- Death of the employee, if he or she is a covered employee under the Plan;
- Divorce or legal separation of the employee and his/her spouse;
- The employee, if a covered employee under the Plan, becomes enrolled in Medicare (Part A, Part B, or both); or
- For dependent children, the dependent child ceases to satisfy the Plan's definition of a "dependent child" (The rules for second qualifying events also apply to newborn or adopted children.)

This thirty-six (36) months total of Continuation Coverage available when a second Qualifying Event occurs includes the number of months you have already been covered under Continuation Coverage because of the first Qualifying Event. The thirty-six (36) month total is not in addition to any months of Continuation Coverage you have already had because of the first Qualifying Event. The Plan Administrator must be notified within sixty (60) days of the second Qualifying Event or the additional extended coverage will not be allowed.

For your reference, below is a table that summarizes COBRA Qualifying Events and the length of coverage available, including any extensions you may qualify for:

Qualifying Event	**Maximum Continuation Period**		
	Employee	**Spouse**	**Child**
Reduction in work hours	18 months	18 months	18 months
Termination (other than for misconduct)	18 months	18 months	18 months
You're determined to be disabled by the SSA	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your Spouse divorce	N/A	36 months	36 months
Your child no longer qualifies as a dependent	N/A	N/A	36 months

Proof of Insurability is Not Necessary to Elect Continuation Coverage

You and your family members do not have to show that you are insurable to purchase Continuation Coverage. But, you must make the required self-payment(s) for such coverage in accordance with specific due dates. The amount(s) and the due date(s) will be shown on the COBRA election notice.

Procedure for Obtaining Continuation Coverage
Once the Fund Office knows that an event has occurred which qualifies you or other family members for Continuation Coverage, the Fund Office will attempt to notify you or your family member of their rights to elect Continuation Coverage.

Once you receive this election notice, you will have sixty (60) days after the date on the election notice within which to notify the Fund Office whether or not you want the Continuation Coverage. If you do not elect the coverage within the sixty (60) day time period, your right to continue your group health care coverage will end.

Termination of Continuation Coverage
The law provides that Continuation Coverage may be cancelled by the Fund for any of the following reasons:

- The Fund no longer provides group health care coverage to any Employees;
- The required self-payment for Continuation Coverage is not paid on time;
- The person remitting Continuation Coverage payments becomes covered under another group health care plan, after the Qualifying Event; or
- The person remitting Continuation Coverage payments becomes entitled to Medicare.

Although your Continuation Coverage may be canceled as soon as you are covered by Medicare, a spouse or a dependent child receiving Continuation Coverage at that time may continue purchasing such coverage for up to eighteen (18) or thirty-six (36) months minus any months of Continuation Coverage received immediately prior to your coverage under Medicare. This option applies only if a spouse or a dependent child is <u>not</u> covered by Medicare.

SECTION 7 — FEDERAL MANDATED NOTICES

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

Under MHPAEA, group health plans generally may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans to ensure that financial requirements (such as coinsurance, copayments and/or deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Your health plan may not, under Federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the mother's or the newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, no pre-authorization from your health plan or the group health insurance insurer is needed for a stay of up to forty-eight (48) hours (or ninety-six (96) hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The medical options provide benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This Federal law states that group health plans provide medical and surgical benefits for mastectomy and must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the medical plans will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of mastectomy, including lymphedema.

Benefits will be provided as they would for any other surgical expense.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Omnibus Budget Reconciliation Act of 1993 requires that group health plans, like the Plan, recognize and comply with "Qualified Medical Child Support Orders." Below are the Fund's procedures for processing medical child support orders that are claimed to be Qualified Medical Child Support Orders.

Receipt of Order

The Fund Office shall promptly notify the participant and each alternate recipient (i.e., a person to receive benefits according to the Order) of the Order's receipt and the Fund's procedures for

determining whether a medical child support order is a Qualified Medical Child Support Order. The Fund Office shall forward a copy of the order to Fund Counsel.

Determination of Qualification
Within a reasonable period after receipt of such Order, the Plan Administrator, with the assistance of the Fund Counsel, shall determine whether such order is a Qualified Medical Child Support order and notify the participant and each alternate recipient of such determination.

The procedures to determine whether medical child support orders are Qualified Medical Child Support orders shall follow the criteria established by Section 609 of the ERISA, as amended and any applicable regulation and administration actions by agencies charged to enforce Section 609. Those criteria include:

- Inclusion of the order in a judgment order or decree made pursuant to state domestic relations law or, is made pursuant to state domestic relations law, or pursuant to a law relating to medical child support described in 42 U.S.C. 1396g issued by a court of competent jurisdiction or administrative process that has the force or effect of law in the state issuing the order.

- Creation, assignment or recognition of the right of an alternate recipient to receive Fund benefits to which a participant or a beneficiary is entitled.

- Whether the alternate recipient is a child of the participant or a child adopted by or placed for adoption with a participant.

- Inclusion of the name and last known mailing address of the affected participant and the name and last known mailing address of the alternate recipient.

- Inclusion of a description of the type of coverage to be provided by the Fund or the manner in which such coverage is to be determined.

- Identification of the period for which the order applies.

- Identification of the Fund as the Plan to which the order applies.

- Certification that the order does not require the Fund to provide benefits or a form of benefits other than one provided by the Plan, provided that the Fund shall satisfy requirements of applicable laws relating to medical child support described in 42 U.S.C. 1908.

Effect of National Medical Support Notices
The Fund shall recognize as Qualified Medical Child Support Orders "National Medical Support Notices" that comply with the provisions of applicable final regulations effective March 27, 2001.

Status of Alternate Recipients
Alternate Recipients shall be deemed Fund participants for purposes of applicable reporting and disclosure requirements and shall be treated as Fund beneficiaries for all other purposes.

Direct Payments
Payments for benefits or claims for reimbursements made by Alternate Recipients under Qualified Domestic Child Support Orders shall be made to the Alternate Recipients or their legal guardians as applicable.

Notification Issues
The Fund Office shall notify an Alternate Recipient or the Alternate Recipient's legal guardian of its determination concerning a medical child support order which is claimed to be a Qualified Medical Child Support Order within a reasonable time after receipt. Alternate Recipients shall be entitled to designate a representative for the receipt of copies of notices that are sent to the alternate Recipient with respect to a medical child support order. The custodial parents or guardians of minor Alternate Recipients shall be considered their designated representatives absent an express written request of other representatives.

SECTION 8 — COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans. Your Blue Cross Blue Shield health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you, your spouse and/or your dependents. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

How COB Works:
If you are covered by more than one group plan, COB guidelines (explained below) determine which carrier pays for covered services first.

- Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan
- Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by the carriers.

GUIDELINES TO DETERMINE PRIMARY AND SECONDARY PLANS

Contract Holder Versus Dependent Coverage
The plan that covers the patient as the employee (subscriber or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts)
If you are the contract holder of more than one health care plan, your primary plan is the one of which you are an active member (such as an employee), and your secondary plan is the one of which you are an inactive member (such as a retiree).

Dependents (The "Birthday Rule")
If a child is covered under both their mother's and father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.

Children of Divorced or Separated Parents
For children of divorced or separated spouses, benefits are determined in the following order unless a court order places financial responsibility on one parent:

1. Plan of the custodial parent.
2. Plan of the custodial parent's new spouse (if remarried).
3. Plan of the non-custodial parent.
4. Plan of non-custodial parent's new spouse.

If the primary plan cannot be determined by using the guidelines above, then the "birthday rule" will be used to determine primary liability.

FILING COB CLAIMS

Remember to ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to the secondary carrier. When you submit claims to BCBSM for reimbursement of the balance, please follow these steps:

1. Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.
2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.
4. Make sure the provider's name and complete address are on your receipts. If the provider is in Michigan, include the provider's Blue Cross Blue Shield of Michigan identification number (PIN). If the provider is located out of Michigan, include the provider's tax ID number.
5. Send these items to:

   COB Department, Mail Code #610J
   Blue Cross Blue Shield of Michigan
   600 E. Lafayette Blvd.
   Detroit, MI 48226-2998

Please make copies of all forms and receipts for your own files, because Blue Cross Blue Shield cannot return the originals to you.

Updating COB Information – Your Responsibility

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, **notify the Fund Office immediately.** Blue Cross Blue Shield may periodically ask you to update your COB information. Please help Blue Cross Blue Shield serve you better by responding to requests for COB information quickly.

SUBROGATION

Your medical plan includes a provision called "Subrogation." If you file a lawsuit or an insurance claim with another carrier, or if there is a settlement with another carrier for which your medical plan had paid for services incurred for which the other carrier is deemed responsible, subrogation allows this Fund and/or BCBSM to hold the other carrier responsible for payment of medical expenses related to the injury. Under the terms of your Plan, the Fund may also recover excess payments, if any, which become due to you, your spouse and/or your dependent or beneficiary.

SECTION 9 — DENTAL BENEFITS

This is intended as an easy-to-read summary of your dental benefits and provides only a general overview. It is not a contract. Additional limitations and exclusions may apply. Detailed information can be found in your Delta Dental Certificate. This Summary of Dental Plan Benefits describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, contact Delta Dental's Customer Service department at **800-524-0149 or access their website at** www.deltadentalmi.com**.**

You can also easily verify your benefit, claim and eligibility information online 24 hours a day, seven days a week by selecting the link for Delta Dental's Consumer Toolkit. The Consumer Toolkit will allow you to print claim forms, ID cards, review on-line Explanation of Benefits (EOB) statements, search the directory for a dentist and research oral health care tips.

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan.

What are my choices and what is the difference between a Delta Dental PPO and a Delta Dental Premier Dentist:

You have a choice of using either a Delta Dental PPO or Delta Dental Premier Dentist or a non-participating dentist. Your out-of-pocket costs will depend on your choice of dentist for services.

Delta Dental PPO Dentists
Delta Dental PPO dentists have agreed to accept the lowest payment amount (in other words greater discounts) as payment in full under Delta Dental's Fee Schedule. Additionally, PPO dentists cannot balance bill for amounts above the Delta payment for approved services. This means that your out-of-pocket costs may be less when using a Delta Dental PPO dentist and that your dental benefit maximum could purchase even more services.

Delta Dental Premier Dentists
If you go to a Delta Dental Premier dentist (**a non-PPO** dentist), you can still have lower out-of-pocket costs while using your dental benefits wisely. Premier dentists receive a higher payment (lower discount) than a Delta Dental PPO dentist but Premier dentists also agree accept the Delta payment as payment in full and to not balance bill for approved services.

Non-participating Dentists
If you go to a non-participating dentist (that is, a dentist who does not participate in the Delta Dental PPO or Delta Dental Premier® program network), you may have greater out-of-pocket costs. Delta Dental's payment for covered services will be based on the dentist's submitted fee or the scheduled fee or the Delta Dental Non-participating fee schedule, **whichever is less**. **Non-participating dentists may also balance bill you.**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. You can obtain a copy of your Certificate by calling Delta Dental's Customer Service department at **800-524-0149.** The percentages below are

applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation*.

DENTAL BENEFIT PLAN OUTLINE

Your plan is a Delta Dental PPO plan. The percentages below will be applied to the lesser of the dentist's submitted fee and Delta Dental's allowance for each service. Delta Dental's allowance may vary by the dentist's network participation.

Control Plan
Delta Dental of Michigan

Benefit Year
January 1 through December 31

Group Number
5466

COVERED SERVICES

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
Diagnostic & Preventive	**Plan Pays**	**Plan Pays**	**Plan Pays**
Brush Biopsy - to detect oral cancer	100%	100%	100%
Diagnostic and Preventive Services - includes exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Sealants – to prevent decay of permanent teeth			
Minor Restorative Services - fillings and crown repair	80%	60%	60%
Endodontic Services - root canals	80%	60%	60%
Periodontic Services - to treat gum disease	80%	60%	60%
Oral Surgery Services - extractions and dental surgery	80%	60%	60%
Other Basic Services - miscellaneous services	80%	60%	60%
Relines and Repairs – to bridges, implants and dentures	80%	60%	60%
Major Services			
Major Restorative Services - Crowns	50%	50%	50%
Prosthodontic Services - includes bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - includes braces	**50%**	**50%**	**50%**
Orthodontic Age Limit -	Up to age 19	Up to age 19	Up to age 19

*****When services are received from a **non-participating** dentist, the percentage in the column indicates the portion of Delta Dental's Non-participating Dentist Fee that will be paid for those services. The Non-participating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

ANNUAL SERVICE MAXIMUMS AND GUIDELINES

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for individuals up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Space maintainers are payable once per area per lifetime for individuals up to age 14.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are covered services on posterior teeth.
- Implants and related services are payable once per tooth in any five-year period.

Maximum Annual Benefit Limit
$1,200 per person per Benefit year (January – December) for all covered services other than orthodontic services (see below).

Orthodontic Services Limit
$2,000 per person **"lifetime"** limit**.**

Deductible
None.

Waiting Period
As defined by your local requirements.

Eligibility
As determined by eligibility guidelines per the Plan Administrator and/or underlying agreements.

Dependent Children Eligibility
Eligible dependent children are covered through the end of the month they turn age twenty-six (26).

Coordination of Benefits (COB)
If you and your spouse are both eligible under this Plan, you may be enrolled as both a Subscriber on your own application card and as a Dependent on your Spouse's application card. Your dependent children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Termination of Benefits
Benefits will cease on the last day of the month in which the employee is terminated.

EXCLUSIONS AND LIMITATIONS

Exclusions
Note: The following is a list of common exclusions that may apply to your benefit plan. This list is not all inclusive. Additional exclusions may apply and can be found in your applicable Delta Dental certificate.

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility.

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. **NOTE**: This provision does not apply to any programs provided under Medicaid or Medicare.

2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.

3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.

4. Services completed or appliances completed before a person became eligible under this Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).

5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/solutions, and relative analgesia.

6. General anesthesia and intravenous sedation for:

    a. surgical procedures, unless medically necessary, or
    b. restorative dentistry.

7. Charges for hospitalization, laboratory tests, and histopathological examinations.

8. Charges for failure to keep a scheduled visit with the Dentist.

9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.

10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.

11. Services or supplies, as determined by Delta Dental, which are specialized techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.

13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.

14. Services or supplies received due to an act of war, declared or undeclared.

15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.

16. Services or supplies that are not within the categories of benefits selected by your employer or organization and that are not covered under the terms of the Delta Dental Certificate.

17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.

18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).

19. Sealants.

20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.

21. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.

23. Veneers.

24. Prefabricated crowns used as final restorations on permanent teeth.

25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between Delta Dental and your employer or organization.

26. Paste-type root canal fillings on permanent teeth.

27. Replacement, repair, relines, or adjustments of occlusal guards.

28. Chemical curettage.

29. Services associated with overdentures.

30. Metal bases on removable prostheses.

31. The replacement of teeth beyond the normal complement of teeth.

32. Personalization or characterization of any service or appliance.

33. Temporary crowns used for temporization during crown or bridge fabrication.

34. Posterior bridges in conjunction with partial dentures in the same arch.

35. Precision attachments and stress breakers.

36. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.

37. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

38. Diagnostic photographs and cephalometric films unless done for orthodontics and orthodontics are a Covered Service.

39. Myofunctional therapy.

40. Mounted case analyses.

41. Any and all taxes applicable to the services.

42. Processing policies that may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating dentists may not charge Members for these services or supplies. All charges from non-participating dentists for the following are your responsibility:

1. The completion of forms or submission of claims.

2. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.

3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.

4. Local anesthesia.

5. Acid etching, cement bases, cavity liners, and bases or temporary fillings.

6. Infection control.

7. Temporary, interim, or provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.

9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.

10. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.

11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.

12. Post-operative X-rays, when done following any completed service or procedure.

13. Periodontal charting.

14. Pins and preformed posts, when done with core buildups.

15. Any substructure when done for inlays, onlays and veneers.

16. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

17. A pulpotomy on a permanent tooth, except on a tooth with an open apex.

18. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.

19. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.

20. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.

21. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.

22. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planning or other periodontal treatment.

23. Full mouth debridement when done within 30 days of scaling and root planning.

24. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.

25. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.

26. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

27. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.

28. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

Note: The following is a list of common limitations that may apply to your benefit plan. This list is not all inclusive. Additional limitations may apply and can be found in your applicable Delta Dental certificate.

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in Delta's records with any Delta Dental Plan or, at the request of your health care Fund, any dental plan:

1. Bitewing x-rays are payable once per calendar year unless a full mouth x-ray which include bitewings has been paid in that same year.

2. Panoramic or full mouth x-rays (which may include bitewing x-rays) are payable once in any five-year period.

3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.

4. Oral examinations and evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.

5. Patient screening is payable once per calendar year.

6. Preventive fluoride treatments are payable twice per calendar year for people under age nineteen (19).

7. Space maintainers for posterior teeth are payable for people under age fourteen (14). A distal shoe space maintainer is only payable for first permanent molars.

8. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.

9. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture.

10. Individual crowns over implants are payable at the prosthodontic benefit level.

11. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age twelve (12).

12. An occlusal guard is payable once in a lifetime.

13. An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age seventeen (17) or during the healing period for people age seventeen (17) and over.

14. Prosthodontic Services limitations:

    a. One complete upper and one complete lower denture are payable once in any five-year period.
    b. A removable partial denture, implant, or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    c. Fixed bridges and removable partial dentures are not payable for people under age sixteen (16).
    d. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
    e. Implant removal is payable once per lifetime per tooth or area (covered only when implants are a covered benefit).
    f. Implant maintenance is payable once per twelve-month period (covered only when implants are a covered benefit).

15. Orthodontic Services Limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits):

    a. Orthodontic services are payable for individuals pursuant to the age limits specified in your Summary of Dental Plan Benefits.
    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment end on the last day of the month in which the patient was last treated.
    c. Upon written notification to Delta Dental and to the patient, a dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

16. Delta Dental's obligation for payment of benefits ends on the last day of coverage. However, Delta Dental will make payment for covered services provided on or before the last day of coverage as long as Delta Dental receives a claim for those services within one year of the date of service.

17. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.

18. Care terminated due to the death of an Eligible Person will be paid to the limit of Delta Dental's liability for the services completed or in progress.

19. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental will make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

    Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

    a. Plastic, resin, porcelain fused to metal, and porcelain crowns on posterior teeth Delta Dental will pay only the amount that it would pay for a full metal crown.
    b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    c. Plastic, resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
    d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
    e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
    f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
    h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless-steel crown.

20. Maximum Payment: All benefits available under this Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.

21. If a deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the deductible applies until the deductible amount is met.

22. Caries risk assessments are payable once in any 36-month period for individuals age three to eighteen (3-18). In the event a caries risk assessment is performed on an individual age two (2) or under, such risk assessment will be treated as a Disallow.

23. Processing policies may limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Eligible Persons for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your Contractor, any dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.

2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.

3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.

4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.

5. Root planing is payable once in any two-year period.

6. Periodontal surgery is payable once in any three-year period.

7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.

8. Tissue conditioning is payable twice per arch in any three-year period.

9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.

10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.

11. Distal shoe space maintainers are only payable for individuals age eight (8) and under.

12. One caries risk assessment is allowed on the same date of service.

13. One caries risk assessment is allowed within a twelve (12) month period when one by the same/dental office.

14. Processing Policies may limit Delta Dental's payment for services or supplies.

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") applies to when an eligible person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this Plan's benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary?
To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the eligible person to this Plan's Subscriber as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. **Non-coordinating Plan**
   If you have another plan that does not coordinate benefits, your other plan will always be primary.

2. **Employee**
   The plan that covers the eligible person other than as an eligible dependent. For example, the plan that covers you as an eligible member is usually primary. However, if the eligible person is a Medicare beneficiary, federal law may reverse this order.

3. **Children (Parents Divorced or Separated)**
   If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

   If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the child's health care expenses, Delta Dental follows the birthday rule (see Rule 4 below).

   If neither of these rules applies, the order will be determined as follows:

   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with custody of the child;
   c. Next, the plan of the parent without custody of the child; and
   d. Last, the plan of the spouse of the parent without custody of the child.

4. **Children and the Birthday Rule**
   The plan of the parent whose birthday is earliest in the calendar year is always primary for children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. **Laid Off or Retired Employees**
   The plan that covers the eligible person as a laid off or retired employee or as a dependent of a laid off or retired employee.

6. **COBRA Coverage**
The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA).

7. **Other Plans**
If none of the rules above determines the order of benefits, the plan that has covered the eligible person for the longer period will be primary.

If the other plan does not have Rule 5 and/or Rule 6 (above) and decides the order of benefits differently from this plan, this plan may ignore either of those rules. In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures, unless prohibited by applicable law.

How Delta Dental Pays as Primary Plan
When Delta Dental is the primary plan, it will pay for covered services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan
When Delta Dental is the secondary plan, it will pay for covered services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan. However, Delta Dental may pay less than it would have paid as the primary plan.

When Benefits are reduced as described above, each benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of this plan.

DEFINITIONS

Adverse Benefit Determination
Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount
The amount permitted under the applicable fee schedule for this Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year
The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year, unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits
Payment for the Covered Services that have been selected under This Plan.

Child(ren)
Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim
A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date
The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment
The percentage of the charge or flat dollar amount, if any, that you must pay for Covered Services.

Contractor
The employer, organization, group, or association sponsoring This Plan.

Covered Services
The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible
The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental
Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Member Plan
An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Deny/Denied/Denial
When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dentist
A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
- **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
- **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member. Plan in his or her state to participate in Delta Dental Premier.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.
- **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists**."

Disallow/Disallowed
When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will not be responsible for payment for such service if you received the service from a Participating Dentist. However, you will be responsible for paying a Nonparticipating Dentist the applicable amount for such service.

Dependent(s)

- Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits
- **Enrollee or Subscriber**
  You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.
- **Member(s)**
  Any Subscriber or Dependent with coverage under This Plan.

Maximum Approved Fee
The Maximum Approved Fee is the lowest of:

- The Submitted Amount
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment
The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Nonparticipating Dentist Fee
The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period
The period of time, as determined by the Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee
The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

PPO Dentist Schedule
The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.

Premier Dentist Schedule
The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate
A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is

based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies
Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Spouse
Your legal spouse.

Submitted Amount
The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Summary of Dental Plan Benefits
A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate and supersedes any contrary provision of this Certificate.

This Plan
The dental coverage established for Members pursuant to this Certificate and your Summary of Dental Plan Benefits.

RECONSIDERATION AND CLAIMS APPEAL PROCEDURE

Reconsideration
If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure
If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within one hundred eighty (180) days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Subscriber's Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

MANNER AND CONTENT OF NOTICE

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right

to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure. This notice will also advise you of your right to an external review with the Department of Insurance and Financial Services ("DIFS") under the Patient's Right to Independent Review Act ("PRIRA").

Pursuant to PRIRA, you or your authorized representative have the right to request an external review of an Adverse Benefit Determination. You are only eligible for the external review process if you have completed the internal formal claims appeal procedure, or if Delta Dental fails to complete the internal process within the allowable timeframe. The request for external review under PRIRA must be submitted within 120 days of your receipt of the final Adverse Benefit Determination.

To request external review of an Adverse Benefit Determination pursuant to your rights under PRIRA, the Health Care Request For External Review Form must be completed and filed with the Department of Insurance and Financial Services, 530 W. Allegan St., 7th Floor, Lansing, MI 48933-1521. The Health Care Request For External Review Form is available on the DIFS website:

www.michigan.gov/documents/cis_ofis_fis_0018_250_78_7.pdf. The request should include a copy of the final Adverse Benefit Determination, along with information and documentation to support your position.

TERMINATION OF COVERAGE

Your Delta Dental coverage may automatically terminate:

- When the Plan Administrator advises Delta Dental to terminate your coverage.
- On the first day of the month for which the Plan Administrator has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any Claim.
- For your Dependent, when they no longer qualify as a Dependent.
- For any other reason stated in the contract between Delta Dental and the Plan Administrator.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Plan Administrator. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

CONTINUATION OF COVERAGE

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?
Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

- Your employment, if applicable, ends for any reason other than your gross misconduct.
- You do not qualify as a Subscriber as set forth in your Summary of Dental Plan Benefits.
- You are divorced or legally separated.
- You die.
- Your Dependent is no longer a Dependent.
- You become enrolled in Medicare (if applicable).
- You are called to active duty for thirty-one (31) or more days in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

GENERAL CONDITIONS

Assignment
Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement
To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the Covered Services that were paid for by Delta Dental;

2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement;
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount);
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights; and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information
While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship
Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment
If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission
Delta Dental will make no payment for services or supplies if a Claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will Disallow the Claim. However, in the event that a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract
No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions
You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status
You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law
This Certificate and the underlying group contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud
If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits
If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application for files a claim containing a false or misleading statement is guilty of insurance fraud. Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call Delta Dental's toll-free hotline at 800-524-0147. **Anti-fraud calls will only be accepted at this number.**

VSP® VISION CARE.

As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs~

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®-the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP network doctor, your satisfaction is guaranteed.
- **Choice of Providers**. The decision is yours to make-choose a VSP network doctor or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you**. Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest-there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®. Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at eyeconlc.com®, VSP's preferred online eyewear store.

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$20	Every calendar year
Prescription Glasses		$20	See frame and lenses
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Tints/Photochromic adaptive lenses • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$0 $50 $80 -$90 $120 - $160	Every calendar year
Contacts (instead of glasses)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Safety Glasses (Employee-only coverage)			
Safety Eye Exam	• Exam to determine safety eyewear needs	$0	Every 12 months
Frame	• $85 allowance for a safety frame • 20% savings on the amount over your allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every 12 months
Lenses	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every 12 months
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
Your Coverage with Out-of-Network Providers			
Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit vsp.com for plan details.			
Exam…….up to $35 Lined Bifocal Lenses….up to $40 Progressive lenses…up to $55 Frame……up to $45 Lined Trifocal Lenses…up to $55 Contacts……up to $105 Single Vision Lenses....up to $25			
VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.			

Contact VSP 800.877.7195 | vsp.com

1. Brands/promotion subject to change
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

PATIENT APPEAL RIGHTS

You have the right to appeal if:

- You do not agree with VSP's decision about your health care
- VSP will not approve or give you care you feel it should cover
- VSP is stopping care you feel you still need

VSP normally has thirty (30) days to process your appeal. In some cases, you have a right to a faster, 24-hour appeal. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting thirty (30) days for a standard appeal. If you ask for a fast appeal, VSP will decide if you get a 24-hour/fast appeal. If not, your appeal will be processed in thirty (30) days. If any doctor asks VSP to give you a fast appeal or supports your request for a fast appeal, it must be given to you.

If you want to file an appeal which will be processed within thirty (30) days, do the following:

File the request in writing with VSP at the following address:
Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

Even though you may file your requests with VSP, VSP may transfer your request to the appropriate agency for processing. Your appeal request will be processed within thirty (30) days from the date your request is received.

If you want to file a fast appeal, which will be processed within twenty-four (24) hours, do the following:

- File an oral or written request for a 24-hour appeal. Specifically state that "I am requesting an expedited appeal, fast appeal or 24-hour appeal." Or "I believe that my health could be seriously harmed by waiting thirty (30) days for a normal appeal."
- To file a request orally, call 800-877-7195, VSP will document the oral request in writing.

Help With Your Appeal,
If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. If you are covered by Medicare, you may contact the Medicare Rights Center toll free at 888-HMO-9050. You may also call the National Aging Information Center at (202) 819-7501 to request the phone number of your local Area Agency on Aging or health Insurance Counseling and Assistance Program (HICAP).

For more information about patient rights visit: www.vsp.com/about-this-site/patients-rights.html.

SECTION 11 — PRIVACY OF HEALTH INFORMATION

A Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's Privacy Notice, distributed to all Plan participants and dependents, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information. This Notice is effective as of December 1, 2018. If you have any questions, contact Privacy Officer at UWUA National Health & Welfare Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275, or (517) 321-7502, (800) 920-8116, or fax (517) 321-7508, or privacyofficer@tici.com.

PRIVACY NOTICE

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within thirty (30) days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within sixty (60) days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting Privacy Officer at UWUA Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275, or (517) 321-7502, (800) 920-8116, or fax (517) 321-7508, or privacyofficer@tici.com.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

- We can share health information about you for certain situations such as:

  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:

  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

YOUR GROUP INSURANCE PLAN BENEFITS

UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH & WELFARE FUND
CLASS 0001
AD&D, LTD, LIFE

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

00417710/00022.0/ /0001/S39285/99999999/0000/PRINT DATE: 2/07/19

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

We, The Guardian, certify that the employee named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

Group Policy No.	Certificate No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

The Guardian Life Insurance Company of America

Stuart J Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3 B110.0023

00417710/00022.0/ /S39285/9999/0001

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CGP-3-TOC-96 B140.0003

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All Options

GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this *plan*.

"Covered person" means an employee insured by this *plan*.

"Employer" means the *employer* who purchased this *plan*.

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means the Guardian *plan* of group insurance purchased by your *employer*.

"You" and "your" mean an employee insured by this *plan*.

CGP-3-R-GENPRO-90 B160.0011

All Options

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90 B160.0004

All Options

Incontestability

This *plan* is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this *plan* replaces a plan your *employer* had with another insurer, we may rescind the *employer's plan* based on misrepresentations made by the *employer* or an *employee* in a signed application for up to two years from the effective date of this *plan*.

CGP-3-R-INCY-90 B160.0003

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All Options

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

All Options

Accident and Health Claims Provisions

Your right to make a claim for any *accident and health* benefits provided by this *plan*, is governed as follows:

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number.

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

Late Notice of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

Accident and Health Claims Provisions (Cont.)

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

Workers' Compensation The *accident and health* benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CGP-3-R-AHC-90 B160.0014

00417710/00022.0/ /S39285/9999/0001 P 3

All Options

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

B264.0003

All Options

Employee Coverage

Eligible Employees To be eligible for employee coverage, you must be an active *full-time employee*. And you must belong to a class of *employees* covered by this *plan*.

Other Conditions You must:

(a) be legally working in the United States.

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

(i) your *employer's* place of business;

(ii) some place where your *employer's* business requires you to travel; or

(iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan*, provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0 B264.0900

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Employee Coverage (Cont.)

All Options

When Your Coverage Starts

Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12.01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

CGP-3-EC-90-2.0 B264.0690

All Options

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan*, or when this *plan* ends for all *employees*. And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0 B264.0703

All Options

Your Right To Continue Group Life Insurance During A Family Leave Of Absence

Important Notice This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

Continuation of Coverage Life and Accidental Death and Dismemberment insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

If Your Group Coverage Would End Group insurance may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group insurance if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty(or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends Insurance may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan*.
- The end of the period for which the premium has been paid.

Definitions As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.

- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0 B264.2450

All Options

GROUP TERM LIFE INSURANCE SCHEDULE

CGP-3-R-SCH-90 B265.0002

All Options

Employee Basic Term Life Insurance

CGP-3-R-SCH-90 B265.0003

All Options

Your Basic Term Life Insurance Amount

Insurance Amount $15,000.00

CGP-3-R-SCH-90 B265.0011

All Options

Reduction of Basic Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 75% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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Employee Basic Term Life Insurance (Cont.)

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 75 but before he or she reaches age 80.

If an employee is less than age 80 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 80, by 85% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 80.

CGP-3-R-SCH-90 B265.0485

All Options

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than $1,000.00.

If we do not approve the proof, your insurance amount will be $1,000.00.

CGP-3-R-SCH-90 B265.0569

All Options

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90 B265.0029

All Options

Your Basic AD&D Insurance Amount

Insurance Amount $15,000.00

CGP-3-R-SCH-90 B265.0031

All Options

Reduction of Basic AD&D Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

Employee Basic Accidental Death and Dismemberment Insurance (AD&D) (Cont.)

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 75% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 75 but before he or she reaches age 80.

If an employee is less than age 80 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 80, by 85% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 80.

CGP-3-R-SCH-90 B265.0496

All Options

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than $1,000.00.

If we do not approve the proof, your insurance amount will be $1,000.00.

CGP-3-R-SCH-90 B265.0571

All Options

LIFE INSURANCE

B270.0070

All Options

Your Group Term Life Insurance

Basic Life Benefit If you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule.

Proof of Death We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.

Your Beneficiary You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your *employer* written notice, unless you've assigned this insurance. But the change won't take effect until your *employer* gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

Assigning Your Life Insurance If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We suggest you speak to your lawyer before you make any assignment. If you decide you want to assign this insurance, ask your *employer* for details or write to us.

Payment to a Minor or Incompetent If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

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Your Group Term Life Insurance (Cont.)

Payment of Funeral or Last Illness Expenses We have the option of paying up to $1,000.00 of this insurance to any blood relative, or relative, by marriage, who incurs expenses for your funeral or last illness if: (a) the death benefit is payable to your estate; or (b) such benefit is payable to a beneficiary who is a minor.

Settlement Option If you or your beneficiary ask us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-LB-MI-90 B270.0191

All Options

Portability Privilege

Applicability This provision applies only to this plan's employee Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment Insurance.

Important Restriction You must provide proof of insurability satisfactory to us.

Portability Of Basic Group Term Life Insurance You may elect to continue all or part of your employee Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

You may port your coverage if coverage under this plan ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.

You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit.

You may not port your coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan.

You may port: (a) the full amount(s) of your Basic term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least $50,000.00.

The Portable Certificate Of Coverage You can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group plan.

The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Basic Life Portability Coverage Premium Notice.

00417710/00022.0/ /S39285/9999/0001 P. 12

Portability Privilege (Cont.)

How To Port To get a portable certificate of coverage, you must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.

Defined Term As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00 B270.0390

All Options

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95 B270.0326

All Options

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

All Options

Converting This Group Term Life Insurance

If Employment Or Eligibility Ends Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

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Converting This Group Term Life Insurance (Cont.)

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends Or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy

The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium" and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How And When To Convert

To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During The Conversion Period

If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

CGP-3-R-LCONV-99 B275.0064

00417710/00022.0/ /S39285/9999/0001 P. 14

All Options

Your Extended Life Benefit With Waiver Of Premium

Important Notice

This section applies to your basic life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent basic life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled

You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your basic life insurance under this section without payment of premiums from you or the employer.

Total Disability or Totally Disabled means, due to sickness or injury, you are:

(a) not able to perform any work for wages or profit; and

(b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

(a) become totally disabled before you reach age 60 and while insured by the group plan; and

(b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or

(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

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Your Extended Life Benefit With Waiver Of Premium (Cont.)

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

When This Extension Begins

Once approved by us, your extended benefit will be effective on the later of:

(a) 09 continuous months from the date active full-time service ends due to total disability; or

(b) the date we approve you for this benefit.

CGP-3-R-LW-TD-99-1 B275.0513

All Options

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

(b) the date we ask you to be examined by our doctor, and you refuse;

(c) the date you do not give us the proof of disability we require;

(d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or

(e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death

We'll pay as soon as we receive:

(a) written proof of your death, that is acceptable to us; and

(b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2 B275.0059

00417710/00022.0/ /S39285/9999/0001 P. 16

All Options

Your Basic Accidental Death And Dismemberment Benefits

The Benefit We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 90 days of the date of the accident.

Covered Losses Benefits will be paid only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

(a) a hand or foot means it is completely cut off at or above the wrist or ankle.

(b) sight means the total and permanent loss of sight.

Payment Of Benefits For covered loss of life, we pay the beneficiary of your basic group term life insurance.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary of your basic group term life insurance.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

CGP-3-R-ADCL1-00 B310.0396

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All Options

Exclusions We won't pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while you are a member of any armed force;
- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-ADCL2-00 B310.0402

All Options

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002

All Options

Employee Coverage

Eligible Employees To be eligible for employee coverage, you must be an active *full-time employee*. And you must belong to a class of *employees* covered by this *plan*.

Other Conditions You must:

(a) be legally working in the United States.

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

(i) your *employer's* place of business;

(ii) some place where your *employer's* business requires you to travel; or

(iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan*, provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved by us in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. Other parts of this coverage explain if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0 B329.0164

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Employee Coverage (Cont.)

All Options

When Your Coverage Starts

Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12.01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

CGP-3-EC-90-2.0 B264.0690

All Options

When Your Coverage Ends

Your long term disability coverage ends on the date your active *full-time* service ends for any reason.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan*, or when this *plan* ends for all *employees*. And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

Employee Coverage (Cont.)

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which was have agreed, in writing, to provide coverage.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

However, if you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if (i) the disability is not excluded under the *plan;* and (ii) benefits are not excluded due to application of this *plan's* pre-existing condition provision; and (b) the period for which benefits are payable under this *plan.*

CGP-3-EC-90-3.0 B329.0175

All Options

Your Right To Continue Group Long Term Disability During A Family Leave Of Absence

Important Notice This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

Continuation of Long Term Disability Coverage Your long term disability coverage may be continued at your employer's option. You must contact your employer to find out if you may continue this coverage.

If Your Group Coverage Would End Group long term disability coverage may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends Coverage may continue until the earliest of the following:

- The date you return to active work.

- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan*.
- The end of the period for which the premium has been paid.

Definitions As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

All Options

LONG TERM DISABILITY HIGHLIGHTS

This page provides a quick guide to some of the plan features about which people most often want to know. But it's not a complete description of your long term disability plan. Read the following pages carefully for a complete explanation of what we pay, limit, and exclude.

CGP-3-LTD2K-HL B380.0244

All Options

Own Occupation Period The first 24 months of benefit payments from this plan.

CGP-3-LTD2K-HL B380.0245

All Options

Elimination Period

For disability due to injury	90 days
For disability due to sickness	90 days

CGP-3-LTD2K-HL B380.0247

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Maximum Payment Period See the following table.

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

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All Options

Benefit Percent 60%

CGP-3-LTD2K-HL B380.0255

All Options

Maximum Monthly Benefit $2,000.00

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LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become disabled due to sickness or injury.

We decide: (a) if you are eligible for this insurance; (b) if you meet the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below. However, Guardian's decisions: (a) will not be inconsistent with Michigan state law; and (b) may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Claim Provisions

Your Duties If you become *disabled* due to *sickness* or *injury* while insured by this *plan*, you must:

(a) Give notice of claim as soon as possible after the date of your *injury* or the start of your *sickness*. Prompt notice will permit us to start case management. See the "Rehabilitation and Case Management" section of this *plan* for details.

(b) Give a complete account of the details of your *sickness* or *injury*. This will include: (i) the cause of your *disability*, if known; (ii) a description of your *sickness* or the accident that caused your *injury*; and (iii) a list of all *doctors*, hospitals, or other facilities where you have been treated for the cause of your *disability*.

(c) Allow release of medical and/or income data needed to assess your claim.

(d) Give periodic medical updates as required by this *plan*.

(e) Take part in any medical, financial or vocational assessment as required by this *plan*.

(f) Apply for other income benefits to which you may be entitled.

(g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.

(h) Promptly report to us changes in your personal status. This includes: (i) change of address or phone number; (ii) changes in how your *disability* affects your daily living; and (iii) changes in your level of social, volunteer or business activities.

(i) If we overpay benefits, promptly report and repay any amount overpaid.

(j) If you are working while *disabled*, promptly report to us the amount of your income from such work.

Claim Provisions (Cont.)

(k) Give us proof of your earnings for the period prior to your *disability* and while you are *disabled*.

Notice You must send us written notice of your intent to file a claim under this *plan* as described in this certificate's "Accident and Health Claims Provisions." Notice must include:

(a) your full name; phone number; social security number; and group number;

(b) the date of your last day worked; the number of hours you worked; and your job title;

(c) your *employer* contact and phone number;

(d) a statement of the nature of your *disability*; and whether or not it is work-related;

(e) your *doctor's* name, address and phone number.

For details, you can call Guardian at 1-800-538-4583.

Proof Of Loss When we receive your notice, we will provide you with a claim form for filing proof of loss. This form requires data from you, the *plan sponsor*, and the *doctor(s)* treating you for your *sickness* or *injury*. Proof of loss must be given to us within the time stated in this certificate's "Accident and Health Claims Provisions." If you do not receive a claim form within 15 days of the date you sent your notice, you should send us written proof of loss without waiting for the form.

We require the items listed below as proof of loss:

(a) During the *elimination period* and the *own occupation* period, medical evidence in support of the limits on your ability to perform your *own occupation*, starting on the date you first became *disabled*. This proof is required from all *doctors* who have treated you for the cause of your *disability*.

After the *own occupation* period, medical evidence in support of the limits on your ability to perform any *gainful work*.

(b) Proof that you have applied for all other sources of income to which you may be entitled, that may affect your payment from this *plan*.

(c) Proof of receipt of other income that may affect your payment from this *plan*.

(d) Your signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. Box 26025
Lehigh Valley, PA 18002-6025

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To Qualify For Payments

How Payments Start

To start getting payments from this *plan*, you must meet all of the conditions listed below:

(a) You must: (i) become *disabled* while insured by this *plan*; and (ii) remain *disabled* and insured for this *plan's elimination period*.

(b) You must be: (i) under a *doctor's regular care* for the cause of your *disability*, starting from the date you were first *disabled*; and (ii) receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*.

(c) You must send us written documentation of: (i) medical evidence in support of the limits causing your *disability*; (ii) your monthly earnings prior to the start of your *disability*; and (iii) any earnings from work while you are *disabled*.

Proof of earnings may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

Waiver Of Premium

Premiums for this insurance are waived while you are entitled to receive a payment from this *plan*.

To Continue Receiving Payments

To continue to receive payments from this *plan*, you must give us current proof of loss when we request it.

You must give proof that satisfies us as to the items listed below:

(a) medical evidence in support of the limits causing your continued *disability*;

(b) continued *regular care* by a *doctor* that is appropriate for the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*;

(c) earnings from work while you are *disabled*; and

(d) any other income that you are entitled to receive.

You must also give us current signed authorizations for release of medical and financial data when we request it.

You must permit such assessments and give us such items within 90 days of the date we make each such request. If you do not, we have the right to suspend or stop your payments under this *plan*.

Right To Request Medical Financial Or Vocational Assessment

We may ask you to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If you do not take part in the assessment, we have the right to stop or suspend your payments under this *plan*.

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All Options

Payment Of Benefits

We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

We pay benefits once each month at the end of the period for which they are payable.

Benefits to which you are entitled may remain unpaid at your death. Such benefits may be paid at our discretion to: (a) your estate; or (b) your spouse, parents, children, or brothers and sisters.

CGP-3-LTD2K-2.1 B380.0015

All Options

GRIEVANCE PROCEDURES FOR DISABILITY INCOME INSURANCE

Definitions

"Grievance" means a written complaint submitted by a *covered person* or his or her *authorized representative* regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an *adverse determination* made pursuant to *utilization review*; (2) benefits or claim payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a *covered person* and Guardian.

"Adverse determination" means a determination made by Guardian or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed, and, based upon the information provided, does not meet Guardian's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced or terminated. Failure to respond in a timely manner to a request for a determination constitutes an *adverse determination*.

When an *adverse determination* is made, Guardian or its designated utilization review organization will provide the *covered person* with a written statement containing the reasons for the *adverse determination* and a written notice of the grievance procedures. If a *covered person* or his or her *authorized representative* does not agree with a determination, he or she may file a *grievance* under the *plan*'s grievance process.

"Authorized representative" means any of the following: (1) a person to whom the *covered person* has given express written consent to represent the *covered person* in the grievance process; (2) a person authorized by law to provide substituted consent for a *covered person*; and (3) if the *covered person* is unable to provide consent, a family member of the *covered person* or the *covered person*'s treating health care provider.

"Commissioner" means the *commissioner* of the office of financial and insurance services of the State of Michigan.

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URO " means a utilization review organization, an entity that conducts *utilization review* (other than Guardian).

"Utilization Review" means a set of formal techniques designed to monitor the use of, evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

Internal Grievance Procedures

The grievance procedures ensure full investigation of a *covered person*'s complaint and provide for timely notification to the *covered person* or his or her *authorized representative* of the progress of the investigation. There are several levels of review available under the internal grievance procedures:

Formal Review A *grievance* may be submitted in writing by the *covered person* or his or her *authorized representative*.

Guardian or its designated *URO* will make a final determination in writing within 35 calendar days after a formal *grievance* is submitted in writing.

The timing of the 35 calendar-day period may be tolled for: (i) any period of time the *covered person* is permitted to take under the grievance procedure, and (ii) for a period not to exceed 10 business days if Guardian or its designated *URO* has not received information requested from a health care provider.

A *covered person* has the right to present a *grievance* before a designated committee of Guardian.

Expedited Review A *covered person* is entitled to an expedited review when a *grievance* has been submitted in writing; AND a doctor, orally or in writing, certifies that the 35 calendar-day time frame of the formal review process would seriously jeopardize the life or health of the *covered person* or the *covered person* 's ability to regain maximum function.

Guardian or its designated *URO* will make a determination within 72 hours after receiving an expedited *grievance*.

If Guardian or its designated *URO* rendered a determination orally, written confirmation of the determination will be provided to the *covered person* within 2 business days after the oral determination.

If the *covered person* is not satisfied with the outcome of the internal grievance process, he or she may submit a written request to the *commissioner* to review the complaint.

Contact Information

To contact Guardian or its designated *URO* regarding *grievances*, the *covered person* or his or her *authorized representative* may write to:

The Guardian Life Insurance Company of America

P.O. Box 8020

Appleton, WI 54912-8020

ATT: Manager, Quality Assurance

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Contact Information (Cont.)

(Contact Person for Receipt of Grievances)

OR

ATT: Grievance Coordinator

(Contact Person for Administration of Grievance Process)

To contact the *commissioner* regarding *grievances*, the *covered person* or his or her *authorized representative* may write to:

Michigan Division of Insurance

P.O. Box 30220

611 W. Ottawa

Lansing, MI 48909-7720

(877) 999-6442 (toll-free)

Maintaining Records

As required by state law, Guardian will record and maintain summary data on the number and types of grievances filed, and will report this data, in the manner specified by the *commissioner*, to the *commissioner* on an annual basis. The data will be reviewed periodically by Guardian's management to assure that appropriate actions have been taken. Copies of all *grievances* and responses will be available at Guardian's principal office for inspection by the Michigan Division of Insurance for two years following the year the *grievance* was filed.

CGP-3-R-DIGRV-MI-01 B380.1273

All Options

When Benefits End

When Payments End

Your benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date you are no longer *disabled*.

(b) The date you earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan*.

(c) The date you are able to perform the major duties of your *own occupation* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(d) After the *own occupation* period, the date you are able to perform the major duties of any *gainful work* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(e) The date you no longer reside in the United States.

(f) The date you die.

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When Benefits End (Cont.)

(g) The end of the *maximum payment period*.

(h) The date you fail to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.

(i) The date you are no longer under the *regular care* of a *doctor*.

(j) The date payments end in accord with a *rehabilitation agreement*.

(k) The date you refuse to take part in a *rehabilitation program*.

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

CGP-3-LTD2K-3.0 B380.0019

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All Options

Maximum Payment Period

The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability*. It is determined by the table shown below.

But, it may be less than that shown due to the nature of your *disability*. See "Special Limitations."

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

CGP-3-LTD2K-3.1 B380.0152

All Options

Special Limitations

We limit the *maximum payment period*, if you are *disabled* due to a condition listed below.

The *maximum payment period* for all such periods of *disability* is 24 months. This is a combined maximum for all such conditions and all periods of *disability*.

We limit the *maximum payment period* for *disabilities* caused or contributed to by the following conditions:

- *Mental or emotional conditions*
- Drug or alcohol abuse
- Musculoskeletal and connective tissue disorders including, but not limited to:
  - Sprains or strains of joints and muscles
  - Soft tissue conditions
  - Repetitive motion syndromes or injuries
  - Fibromyalgia
- Chronic fatigue conditions including, but not limited to:
  - Chronic fatigue syndrome
  - Chronic fatigue immunodeficiency syndrome
  - Epstein-barr syndrome

When Benefits End (Cont.)

- Chemical and environmental sensitivities
- Headache
- Chronic pain, myofascial pain
- Gastro-esophageal reflux disorder
- Irritable bowel syndrome
- Vestibular dysfunction, vertigo, dizziness

This limitation will not apply to *disabilities* caused or contributed to by the following conditions:

- Schizophrenia
- Dementia
- Organic brain syndromes
- Amnesia syndromes
- Organic delusional or hallucinogenic syndromes
- Arthritis
- Ruptured intervertebral discs
- Spinal fractures
- Osteopathies
- Spinal tumors, malignancy or vascular malformations
- Radiculopathies, documented by EMG
- Spondylolisthesis, Grade II or higher
- Myelopathies
- Demyelinating diseases
- Traumatic spinal cord necrosis

No benefits will be paid for *disability* due to a *mental or emotional condition* or drug or alcohol abuse if you are not receiving treatment for the cause of the *disability* from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

When Benefits End (Cont.)

If payments under this *plan* would end due to the limits in this section, we may extend such payments, as shown below. But, you must meet all of the following conditions: (a) you must be *disabled* due to a condition named above; (b) you must be an inpatient in a qualified institution because of your *disability*; and (c) you must have been treated as an inpatient for at least 14 days in a row. In such case, we extend payments until the earliest of: (i) 90 days from the date of your discharge; (ii) the end of this *plan's maximum payment period*; or (iii) the date your *disability* ends.

The term "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your *disability*.

If This Plan Ends This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all insureds, or for your class. If you are *disabled* when this insurance ends, we will treat you as if your insurance did not end. But, your benefit will be based on all of the terms of this *plan*.

CGP-3-LTD2K01-3.2 B380.0430

All Options

To Determine Your Benefit

Your benefit is determined by the plan of benefits and your *insured earnings* in effect on the date your *disability* starts.

Any changes to this *plan* that take place while you are *disabled* will not affect how we determine your benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability*.

Determining Your Monthly Benefit

Your *monthly benefit* is determined as shown below.

(a) Multiply your *insured earnings* by 60%. Round this amount to the nearest dollar.

(b) If the amount determined above is less than this *plan's maximum monthly benefit*, that amount is your *gross monthly benefit*.

If the amount determined above is equal to or more than this *plan's maximum monthly benefit*, your *gross monthly benefit* is equal to the *maximum monthly benefit*.

(c) From your *gross monthly benefit*, subtract the amount of any income listed in "Income We Integrate With" that you receive or are entitled to receive. The result is your *monthly benefit*.

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The amount of your *gross monthly benefit* may be limited if the *plan sponsor* has not updated the amount of your *insured earnings* to reflect your then current *insured earnings* on the most recent reporting date prior to the start of your *disability*.

See the "Redetermination" of this *plan* for details.

CGP-3-LTD2K-4.0 B380.0033

All Options

Redetermination This plan redetermines *insured earnings* for each covered person on the date a change in a covered person's *insured earnings* occurs. The *plan sponsor* must report updates to all covered persons' *insured earnings* as they occur. Changes to a covered person's *insured earnings* are subject to any proof of insurability requirements of this *plan*. As of this *plan's* redetermination date, we use a covered person's *insured earnings* on record with us to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan*. However, the covered person must be *actively-at-work* on a full-time basis on that date. If he or she is not, we do not do this until the date he or she returns to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability*.

CGP-3-LTD2K01-4.2 B380.0435

All Options

Income We Integrate With You may receive, or be entitled to receive, income shown in the list below. We will integrate your *gross monthly benefit* with such income to determine your *monthly benefit* from this *plan*.

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of: (1) the *plan sponsor*; or (2) your *employer*. This includes payments made by a group life insurance plan due to your *disability*. This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan.
- Income from a sick leave or salary continuance plan. This applies whether such plan is sponsored on a formal or informal basis. This includes lump sum or recurrent payments of accrued sick leave benefits.
- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

To Determine Your Benefit (Cont.)

(a) All disability benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your *disability;*

(b) All unreduced retirement benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your qualification; and

(c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children due to your receipt of such benefits.

We will integrate your *gross monthly benefit* with such benefits to which your spouse and children are entitled due to your receipt of, or qualification for, disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- *Retirement plan retirement benefits* funded for your benefit by: (1) the *plan sponsor;* or (2) your *employer*.
- *Retirement plan disability benefits*.
- *Retirement benefits* or *retirement plan disability benefits*, due to your *disability*, from any *government plan* other than those shown above.
- Disability benefits from any: (1) *no-fault motor vehicle* coverage; (2) motor vehicle financial responsibility act; or (3) like law.
- Benefits from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of Maintenance, Wages or Cure.
- Disability benefits from any third party when your *disability* is the result of the negligence or intentional tort liability of that third party.
- Payment from your *employer* as part of a termination agreement.

We integrate your *gross monthly benefit* with income shown above that you are entitled to receive without regard to the reason you are entitled to receive it.

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

CGP-3-LTD2K-4.3 B380.0058

All Options

Lump Sum Payments Of Other Income

Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine your *monthly benefit*. If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the *maximum payment period*.

Cost Of Living Freeze

You may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce your *monthly benefit* by the amount of such increase.

Application For Other Income

You must apply for other income benefits to which you may be entitled. If these benefits are denied, you must appeal until: (a) all possible appeals have been made; or (b) we notify you that no further appeals are required.

If we feel you are entitled to receive such income benefits, we will estimate the amount due to you and your spouse and children. We will take this estimated amount into account when we determine your *monthly benefit*. But, we will not take this estimated amount into account if you sign our reimbursement agreement. In this agreement you promise: (a) to apply for any benefits for which you may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount we overpaid due to an award of such benefits.

If we do reduce your *gross monthly benefit* by an estimated amount, we will adjust your *monthly benefit* when we receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We will assist you in applying for other income benefits.

CGP-3-LTD2K-4.4 B380.0062

All Options

Minimum Payment

The minimum monthly payment for *disability* under this *plan* is $50.00.

Partial Month Payment

You may be *disabled* for only part of a month. In this case, we compute your payment as 1/30th of the benefit to which you would be entitled for the full month times the number of days you are *disabled*. Payment will not be made for more than 30 days in any month.

Overpayment Recovery

If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

CGP-3-LTD2K-4.5 B380.0064

All Options

If You Work While Disabled

Income Earned During Disability

Subject to the other terms of this *plan*, if you are working to your *maximum capacity*, income earned during disability is treated as shown below while this *plan* pays benefits. In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

1. For each of the first 12 months after you return to work, add your *gross monthly benefit* and your *income earned during disability*.
   (a) If the sum is not more than 100% of your *insured earnings*, we do not reduce your *monthly benefit* for that month.
   (b) If the sum is more than 100% of your *insured earnings*, we reduce your *monthly benefit* for that month by the amount over 100% of your *insured earnings*.
2. For each month after 12 months of work while *disabled*:
   (a) If your *income earned during disability* is less than 20% of your *insured earnings*, we do not reduce your *monthly benefit* for that month.
   (b) If your *income earned during disability* is 20% or more of your *insured earnings*, we reduce your *monthly benefit* for that month by 50% of your *income earned during disability*.

CGP-3-LTD2K01-5.0 B360.0442

All Options

Part-Time Earnings Capacity

If you are able to work *part-time* while *disabled*, but you are not working to your *maximum capacity*, we adjust the *monthly benefit* as follows.

During the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity*, in your *own occupation*. After the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity*, in any *gainful occupation*.

Maximum Income Earned During Disability

This *plan* limits the amount of income you may earn, or may be able to earn, and still be considered *disabled*.

If your *income earned during disability* is more than the limit shown below, payments from this *plan* will end. Payments from this *plan* will also end if you are able to earn more than the limit shown below.

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If You Work While Disabled (Cont.)

(a) During the *own occupation* period, the limit is 80% of your *insured earnings*.

(b) After the *own occupation* period, the limit is 60% of your *insured earnings*.

In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

CGP-3-LTD2K01-5.1 B380.0518

All Options

Indexing If you return to work while *disabled*, we adjust your *insured earnings* each year. We do this by means of an indexing factor. This factor increases the amount of income you may earn and still be considered *disabled*. This adjustment does not increase your *gross monthly benefit*, *monthly benefit*, or any other benefit under this *plan*.

We make the first indexing adjustment after you: (a) have returned to work; and (b) have received 12 monthly payments in a row from this *plan*.

To make the first adjustment, we multiply your *insured earnings* by the indexing factor for that year. To make adjustments in each later year, we multiply the amount of your last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the percentage change in the *CPI-W* for the prior calendar year.

CGP-3-LTD2K-5.2 B380.0073

All Options

Recurring Disability

Your benefits from this *plan* will end because you cease to be *disabled*. In this case, a later *disability* may be treated as a *recurring disability*. The terms listed below must be met:

(a) You return to *active work* right after your benefits end;

(b) Your *disability* recurs less than six months after you were last entitled to benefits;

(c) Your later *disability* is due to the same cause of, or a cause related to the cause of, your earlier *disability*;

(d) This *plan* does not end during your return to *active work*;

(e) You do not become covered under any other similar group income replacement plan during the time you return to *active work*; and

(f) During the time you return to *active work*, you stay insured by this *plan* and premium payments are made on your behalf.

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Recurring Disability (Cont.)

(g) Your benefits do not end because you have used up the *maximum payment period*.

Any changes in benefit or the *plan* which take place during your return to *active work*, will not apply to the *recurring disability*.

If the later *disability* is a *recurring disability*, you will not need to complete a new *elimination period* before becoming entitled to benefits. Your claim for *recurring disability* will be subject to the same terms of the *plan* as your earlier *disability*.

CGP-3-LTD2K-6.0 B380.0075

All Options

Services Available

Social Security Assistance

We may feel you are qualified for Social Security disability benefits. If so, we may offer to help you apply for them. If such benefits are under review by Social Security, we may also offer to help you keep them.

We may offer to help:

(a) Fill out your application for such benefits, and any related forms;

(b) Find suitable legal counsel; and

(c) Give medical and vocational data needed to file your claim.

You must apply for all income benefits for which you may be eligible, whether or not you use our help. Using our help does not cancel your duties shown in the "Application for Other Income" section of this *plan*.

Rehabilitation And Case Management

Case management starts when we are notified of your *disability*.

We will review your *disability* to see if certain services are likely to help you return to *gainful work*. If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program*. We have the right to suspend or end your *monthly benefit* if you do not accept it.

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer*, if needed. The program may include, but is not limited to:

(a) vocational assessment of your work potential;

(b) coordination and transition planning with an employer for your return to work;

(c) consulting with your *doctor* on your return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining;

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Services Available (Cont.)

(f) child care expense aid; and

(g) aid in worksite alteration made to comply with the Americans with Disabilities Act. This includes a one-time payment of up to $2,500.00.

We have the right to determine which services are appropriate.

If you accept the *rehabilitation agreement*, we will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

(a) The date your benefits from this *plan* end;

(b) The date you violate the terms of the *rehabilitation agreement*;

(c) The date you end the *rehabilitation program*; and

(d) The date the *rehabilitation agreement* ends.

If you end a *rehabilitation program* without our consent, you must repay any enhanced benefits paid.

CGP-3-LTD2K-8.0 B360.0089

All Options

Pre-Existing Conditions

Pre-Existing Conditions

A pre-existing condition is a *sickness* or *injury*, including all related conditions and complications, for which, in the look back period, you:

(a) receive advice or treatment from a *doctor*;

(b) take prescribed drugs; or

(c) receive other medical care or treatment, including consultation with a *doctor*.

You may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the six months before the latest of: (a) the effective date of your insurance under this *plan*; (b) the effective date of a change that increases the benefits payable by this *plan*; and (c) the effective date of a change in your benefit election that increases the benefit payable by this *plan*.

A pregnancy that exists on the date your insurance under this *plan* starts is also a pre-existing condition.

No benefits are payable for *disability* due to a pre-existing condition, unless the *disability* starts after you complete at least one full day of *active work* after the date you are insured under this *plan* for 24 months in a row.

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Pre-Existing Conditions (Cont.)

You may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan*; or (b) a change in your benefit election which increases the benefit payable by this *plan*. In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if your *disability* starts after you complete at least one full day of *active work* after the change has been in force for 24 months in a row.

We do not cover any *disability* that starts before your insurance under this *plan*.

CGP-3-LTD2K-9.0 B380.0090

All Options

Prior Coverage Credit

If this *plan* replaces a similar income replacement plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start right after the old plan ends.

We credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision, we credit any time you were covered under the old plan toward meeting this *plan's* pre-existing condition provision. We do this if: (a) you were covered under the old plan when it ended; and (b) you are *actively-at-work* and enroll for insurance on the effective date of this *plan*.

But, we limit the *maximum monthly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum monthly benefit* to an amount equal to the old plan's maximum.

We deduct all payments made by the old plan under an extension provision.

CGP-3-LTD2K-9.1 B380.0092

All Options

Not Covered

Exclusions

This *plan* does not pay benefits for *disability* caused by, or related to:

(a) declared or undeclared war, act of war, or armed aggression;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) your taking part in a riot or civil disorder;

(d) your commission of, or attempt to commit a crime; or

(e) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability*.

Not Covered (Cont.)

(1) during which you are confined to a facility as a result of your conviction of a crime;

(2) during which you are not receiving regular care by a *doctor*;

(3) during which you are not receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*;

(4) which starts before you are insured by this *plan*; or

(5) during which your loss of earnings is not solely due to your *disability*.

CGP-3-LTD2K-10.0 B380.0093

All Options

Definitions

Active Work, Actively-At-Work Or Actively Working You are able to perform and are performing all of the regular duties of your work for your *employer*, on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CGP-3-LTD2K-12.0 B380.0098

All Options

CPI-W That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. When we compute the change in *CPI-W*, we use the value of the *CPI-W* published in December of that year and the value published in December of the prior year. If the Department of Labor stops publishing the *CPI-W*, we have the right to use some other similar standard.

CGP-3-LTD2K-12.2 B380.0100

All Options

Disability Or Disabled These terms mean you have physical, mental or emotional limits caused by a current *sickness* or *injury*. And, due to these limits, you are not able to perform the major duties of your *own occupation* or any *gainful work* as shown below:

(1) During the *elimination period* and the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of your *own occupation*.

(2) After the end of the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of any *gainful work*.

Definitions (Cont.)

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *income earned during disability*.

You may be required, on average, to work more than 40 hours per week. In this case, you are not *disabled* if you are able to work for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability*.

CGP-3-LTD2K-12.3 B380.0102

All Options

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize you, or your spouse, child, parent, sibling, or business associate, as a *doctor* with respect to your claim for this *plan's* benefits.

Elimination Period The period of time you must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

Any days during which you return to *active work* will not count toward the *elimination period*. The *elimination period* will be extended by one day for each day of *active work*. If you become eligible under any other similar group income replacement plan while you are at *active work*, you will not be entitled to benefits from this *plan*.

Employer The business entity that employs you and is: (a) the *plan sponsor*; or (b) associated with the *plan sponsor*.

CGP-3-LTD2K-12.10 B380.0112

All Options

Gainful Occupation or Gainful Work Work for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. When you are able to perform such work on a full-time basis, you can be expected to earn at least 60% of your indexed *insured earnings*, within 12 months of returning to work.

Government Plan Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

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Definitions (Cont.)

Gross Monthly Benefit This *plan's monthly benefit* before it is reduced by other income and earnings.

Income Earned During Disability The monthly income you earn from working while *disabled*. It includes any income you earn while *disabled* but which is returned to your *employer*, partnership, or any other similar business arrangement to cover any business or overhead expenses.

Injury A bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan*. We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury*.

CGP-3-LTD2K01-12.11 B380.0458

All Options

Insured Earnings Only your earnings from the *employer* will be included as *insured earnings*.

We calculate benefit amounts and limits based on the amount of your *insured earnings* on record with us as of the Redetermination date immediately prior to the start of your *disability*. See the "Redetermination" section of this *plan*.

Insured earnings includes your contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

For all covered persons, *insured earnings* means your rate of monthly earnings, excluding bonuses, commissions, expense accounts, and any other extra compensation, as reported by the *plan sponsor*. If you are paid hourly, we calculate monthly earnings based on actual hours worked or billed in the two months before the start of your *disability*. We do not include pay for hours worked or billed over 40 per week. Such earnings are multiplied by 4.333.

CGP-3-LTD2K01-12.12 B380.0466

All Options

Maximum Capacity During the *own occupation* period, the fullest extent of work you are able to do in your *own occupation*. After the *own occupation* period, the fullest extent of work you are able to do in any *gainful occupation*. We decide the fullest extent of work you are able to do based on objective data provided by: (a) your treating *doctor*; (b) impartial medical or vocational exams; (c) peer review specialists; (d) functional capacities exams; and (e) other medical and vocational specialists whose area of expertise is appropriate to your *disability*.

Maximum Payment Period The longest time that benefits are paid by this *plan*.

Mental Or Emotional Conditions Include, but are not limited to: (a) neurosis; (b) psychoneurosis; (c) psychosis; (d) psychopathy; and (e) any other mental or emotional disorder.

Monthly Benefit This *plan's gross monthly benefit* reduced by other income. If you are working while *disabled*, your *monthly benefit* will be further reduced based on the amount of your *income earned during disability*. See the "If You Work While Disabled" provision of this *plan* for how this is done.

CGP-3-LTD2K01-12.13 B380.0489

All Options

No-Fault Motor Vehicle Coverage A motor vehicle plan that pays disability or medical benefits no matter who was at fault in an accident.

Own Occupation Your occupation as done in the general labor market in the national economy. To determine the duties and requirements of your *own occupation*, we use: (a) the job description provided by the *plan sponsor*; and (b) the duties and requirements of that occupation as shown in the most recent version of the Dictionary of Occupational Titles. That document is published by the Department of Labor. If the Department stops publishing that document, we have the right to use some other similar standard.

Part-Time The ability to work and earn between 40% and 80% of *insured earnings* during the *own occupation* period and between 40% and 60% of *insured earnings* after the *own occupation* period.

Plan Sponsor The employer, association, union, trustee, or other group to which this *plan* is issued.

Recurring Disability A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular Care A person is being treated by, or in consultation with, a *doctor* at a frequency that is consistent with his or her condition. The requirement for *regular care* does not apply if he or she has reached his or her maximum point of recovery yet is still disabled under the terms of this *plan*.

CGP-3-LTD2K01-12.14 B380.0522

All Options

Rehabilitation Agreement A formal agreement between: (a) you; (b) us; and (c) your *employer*, if needed. It outlines the *rehabilitation program* in which you agree to take part.

Rehabilitation Program A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits*. When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan*.

We, Us, And Guardian The Guardian Life Insurance Company of America.

You The person insured by this *plan*.

CGP-3-LTD2K-12.15 B380.0135

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

Employee means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

CGP-3-GLOSS-90 B750.0006

All Options

Employer means UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH & WELFARE FUND

CGP-3-GLOSS-90 B900.0051

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.

CGP-3-GLOSS-90 B750.0229

All Options

Plan means the *Guardian* group *plan* purchased by your *employer*, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

CGP-3-GLOSS-90 B900.0039

All Options

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

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All Options

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

All Options

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004
(212) 598-8000

Your group term life insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Life Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Life Insurance Claims

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination l is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Life Insurance Claims

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

B997.0364

All Options

Appeals of Adverse Determinations of Life Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium

If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

The benefit determination period begins when claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the time period shown below. A written or electronic notification of any adverse determination must be provided.

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0365

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0366

All Options

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004
(212) 598-8000

Your group term accidental death and dismemberment insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Accidental Death and Dismemberment Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Accidental Death and Dismemberment Insurance Claims

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Accidental Death and Dismemberment Insurance Claims

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement, that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0367

All Options

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Waiver of Premium

If you apply for an extension of accidental death and dismemberment insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the time period shown below. A written or electronic notification of any adverse determination must be provided.

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0368

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0369

All Options

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004
(212) 598-8000

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Disability Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

B997.0370

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;

- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- In the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0371

All Options

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

  UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH & WELFARE FUND Plan

- **Employer's Name:** (Plan Sponsor)

  UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH & WELFARE FUND

  Address: 6525 CENTURION DRIVE
  LANSING MI 48917

  Phone Number: 517-321-7502

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**200027580

- **Plan Number:** 501

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

  UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH & WELFARE FUND

  Address: 6525 CENTURION DRIVE
  LANSING MI 48917

  Phone Number: 517-321-7502

- **Agent for the Service of Legal Process:**

  UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH & WELFARE FUND

  Address: 6525 CENTURION DRIVE
  LANSING MI 48917

  Phone Number: 517-321-7502

  (Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.

- **Date of End of Record Year:** October 1st .

- **Sources of Contribution:**Contributions to the plan are provided by:

  - the Employer

- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)

- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.

- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.

- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0084

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

Guardian

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004-2616

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SECTION 13 — MISCELLANEOUS PLAN PROVISIONS

THE TRUSTEES INTERPRET THE PLAN

Under the Fund's Trust Agreement, and the Plan's terms, the Board of Trustees have the sole authority to interpret the Trust Agreement and the Plan, and to make final determinations regarding any benefit application and to interpret the Plan and any administrative rules adopted by the Trustees (except to the extent this authority has been delegated to BCBSM, Delta Dental, VSP or Guardian). The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Trust, and the Plan documents so provide, that such decision is to be upheld unless the Court determines the decision is arbitrary or capricious.

Any interpretation of the Plan's provisions rests solely with the Board of Trustees. Benefits under this Plan will be paid only if the Trustees decide, in their discretion, that the applicant is entitled to them. As stated earlier in this SPD, **no employer or Union**, nor any representative of any Employer or Union, is authorized to interpret this Plan on behalf of the Board nor can an Employer or Union act as an agent of the Board of Trustees.

The Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from participants regarding eligibility rules, benefits, and claims procedures. But, if there are any questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination.

PLAN AMENDMENTS

The Trustees have the legal right to change the Plan, subject to any applicable collective bargaining agreement. The Trustees have the authority to amend the Plan's terms and to change or eliminate benefits (with or without notice),

The Trustees hope to maintain the Plan's present level of benefits and to improve upon them, if possible. But, the Trustees must protect the Plan's financial soundness at all times. This duty requires changes from time to time.

Changes in the Plan may also be required to preserve the Fund's tax-exempt status under IRS rules and regulations. These IRS rules and regulations may change. So, the Trustees may have to change Plan provisions to retain the Trust's tax-exempt status, and to comply with changes in the law.

TAX EXEMPT STATUS

The IRS has classified the Fund as an IRC Section 501(c)(9) VEBA Trust. This means that the Employers' contributions to the Trust are tax deductible.

Also, in most cases, the benefits paid on your behalf are not taxable as personal income. Similarly, the investment earnings on Plan assets are not taxed because they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption has advantages that work to the benefit of both Employers and Employees. It means that money which otherwise might be payable as taxes can be used to purchase health-care benefits and to cover the Plan's administrative expenses.

The Trustees understand these advantages and will take whatever steps are necessary to keep your Plan "qualified" as an IRS tax-exempt trust.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the applicability of and to implement the terms of this Plan or the similar terms of any other plan, the Fund may, without consent or notice to any covered person, release to or obtain from any insurance company or other organization or individual, any information, with respect to any covered person, which the Fund deems to be necessary for such purposes. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

PAYMENT OF CLAIMS

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which are prescribed herein effective at the time of payment. If no such designation or provision is then effective, the indemnity will be payable to the estate of the Employee. Any other accrued indemnities unpaid at the Employee's death may, at the option of the Trustees, be paid either to the beneficiary or to the estate.

Subject to any written direction of the Employee, all or a portion of any indemnities provided by the Fund for services rendered by a hospital, nursing, medical, surgical, pharmacy, dental or vision service may, at the Trustees' option, and unless the Employee requests otherwise in writing no later than the time for filing proof of loss, be paid directly to the hospital or provider of services.

PLAN TERMINATION

Although the Trustees do not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. The Trustees determine that the Fund assets are not adequate to carry out the purpose for which the Fund is intended; or
2. There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer contributions to be made to the Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Fund Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be used to continue Plan benefits after the Plan termination date for those persons eligible when the Plan was terminated.

Upon written request, you may examine the agreement at the Administration Office or other specified locations, or you my request of a copy of the agreement, which will be provided for a reasonable charge.

FUTURE OF THE PLAN

The Trustees reserve the right to change or end any of the Plan's benefits (or discontinue the Plan) at any time. The Trustees' decision to change or end any of the Plan's benefits (or to discontinue the Plan) may be due to changes in the Federal or State laws governing benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or a policy involving an insurance company, or any other reason. Any such action would be memorialized in the minutes of the Fund's Board of Trustees' meetings or would be taken in writing and maintained as part of the records of the Plan.

LIMITATION ON ASSIGNMENT

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to anyone else except under limited circumstances (*e.g.,* Qualified Medical Child Support Order or assignment to your health provider).

SECTION 14 — YOUR ERISA RIGHTS

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a Plan participant, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as at a worksite, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if one is required. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event, and if your Plan, because of the size and nature of your employer, is subject to the COBRA regulations. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire

you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 15 — NONDISCRIMINATION POLICY

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

The Fund 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)
- 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 the Fund Office.

If you believe that the Plan 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: UWUA National Health & Welfare Fund Office, Health Care Department Manager, 6525 Centurion Drive, Lansing, Michigan 48917, (phone) 800-920-8116, (fax) 1-517-321-7508, (e-mail) HCDmanager@tici.com. You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, the Health Care Department Manager, 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 www.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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-920-8116.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-920-8116.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
800-920-8116。
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-920-8116 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-920-8116.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-920-8116 (رقم هاتف الصم والبكم:).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-920-8116.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-920-8116.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 800-920-8116

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-920-8116.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-920-8116.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 800-920-8116 पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-920-8116.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 800-920-8116.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-920-8116.

APPENDIX A. NOTICE OF GRANDFATHERED STATUS

The Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at **800-920-8116**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **866-444-3272** or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

APPENDIX B. – TRUSTEES ROSTER

UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH AND WELFARE FUND

EMPLOYER TRUSTEES	UNION TRUSTEES
Lee Ellis, Secretary Transmission Maintenance Construction 28175 Haggerty, Suite 152 Novi, MI 48377	Patrick M. Dillon, Chairman 3534 Twin Spruce Drive Kalamazoo, MI 49004 (Effective October 4, 2019)
Nathan Fisher NPL Construction 19820 North 7th Avenue, Suite 120 Phoenix, AZ 85027 (Effective February 26, 2019)	Michael A. Coleman Utility Workers Union of America AFL-CIO 815 16th Street, NW Washington, DC 20006
Kevin Jenkins Indian Point Energy Center (IPEC) Training Building 450 Broadway, Suite 1 PO Box 249, Mail Stop: K-IP-l140 Buchanan, NY 10511	Shawn Garvey 1300 L St. NW Washington, DC 20005
Rodney LeBeau Utility Lines Construction Services 12500 E. 10 Mile Road Warren, MI 48089	Ryan Payne PO Box 873 Bridgeport, WV 26330 (Effective April 3, 2019)
Mark H. Morton American Water 1 Water Street Camden, NJ 08102 (Effective February 27, 2019)	Michael Sallach 515 Pittsburgh Mills Circle Tarentum, PA 15084