Western Michigan Health Insurance Pool
Group Number: 71565   Package Code(s): 068
Section Code(s): 1020, 1120
PPO - CB500, RX1, Hearing
Effective Date: 01/01/2018

Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.
### Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles - per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $500 per member</td>
<td>$1,000 per family</td>
<td>$1,000 per member $2,000 per family</td>
</tr>
<tr>
<td>Copays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fixed Dollar Copays</td>
<td>$20 copay for:</td>
<td>No Copay</td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Percent Coinsurance</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>• 20%</td>
<td>Note: Services without a network are covered at the in-network level.</td>
<td></td>
</tr>
<tr>
<td>Annual out-of-pocket maximums</td>
<td>$2,500 per member</td>
<td>$3,000 per member $6,000 per family</td>
</tr>
<tr>
<td></td>
<td>$5,000 per family</td>
<td>Includes Deductible, Coinsurance and Copays</td>
</tr>
<tr>
<td></td>
<td>Includes Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Lifetime dollar maximum</td>
<td>$2,500 per member</td>
<td>$3,000 per member $6,000 per family</td>
</tr>
<tr>
<td></td>
<td>$5,000 per family</td>
<td>Includes Deductible, Coinsurance and Copays</td>
</tr>
<tr>
<td></td>
<td>Includes Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Care Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Exam - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Pap Smear Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mammography Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Contraceptive Methods and Counseling</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Endoscopic Exams one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 8 visits per calendar year, birth through 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits per calendar year, 13 months through 35 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 visits per calendar year, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations - pediatric and adult</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Physician Office Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Services are payable when rendered by American Well or BCBS providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Surgical Consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Surgical Consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Surgical Consultations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Emergency Medical Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Emergency Room</td>
<td>Covered - 100%</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Qualified medical emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency use of the Emergency Room</td>
<td>Covered - 100% after $25 copay</td>
<td>Covered - 100% after $25 copay</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Professional</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Ambulance Services - Medically Necessary Transport</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
</tbody>
</table>

# Diagnostic Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI, MRA, PET and CAT Scans and Nuclear Medicine</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Laboratory &amp; Pathology</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

# Maternity Services Provided by a Physician

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postnatal Care Visits</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

# Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Inpatient Medical Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

# Alternatives to Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>Covered - 100%</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 120 days per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Surgical Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (includes related surgical services)</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after in-network deductible</td>
</tr>
<tr>
<td>Wisdom teeth extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilization - males only</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>excludes reversal sterilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilization - females only</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>excludes reversal sterilization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Human Organ Transplants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Organ Transplants</td>
<td>Covered - 100%</td>
<td>Not covered except in designated facilities</td>
</tr>
<tr>
<td>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney, Cornea, Bone Marrow and Skin</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

### Behavioral Health Care and Substance Abuse Treatment Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Inpatient Substance Abuse Treatment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Care</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>• Online Behavioral Health Visits</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Treatment</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 90% after deductible</td>
</tr>
</tbody>
</table>

### Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Behavioral Analysis (ABA)</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Pre-authorization required</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational and Speech therapy with an autism diagnosis is unlimited</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

### Other Covered Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Chiropractic Spinal Manipulation</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Allergy Testing and Therapy</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

### Therapy Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a combined maximum of 60 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.
Western Michigan Health Insurance Pool  
Group Number: 71565    Package Code(s): 068  
Section Code(s): 1020, 1120  
Prescription Drugs  
Effective Date: 01/01/2018  
Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

### Member’s responsibility (copays and coinsurance amounts)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| Retail - 30 day supply          | $10 copay - Generic drugs  
                                   | $40 copay - Brand drugs  
                                   | $0 copay – OTC drugs  
                                   | (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children’s Claritin, Claritin RediTabs and Claritin-D)  
                                   | Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member’s copay. |
| Mail Order - 90 day supply      | $20 copay - Generic drugs  
                                   | $80 copay - Brand drugs |
| Specialty Drugs – 30 day supply | $10 copay - Generic drugs  
                                   | $40 copay - Brand drugs |
| Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA | Covered - 100% |
| Oral and Injectable Contraceptives | Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance |
| Additional Services             |                                                                          |
| Smoking Cessation Drugs         | Covered                                                                  |
| Weight Loss Drugs               | Covered                                                                  |
| Impotency Drugs                 | Covered                                                                  |
| Infertility Drugs               | Covered                                                                  |
| Diabetic Supplies               | Not Covered                                                               |

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
## Features of your prescription drug plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior authorization/step therapy</strong></td>
<td>A process that requires a physician to obtain approval from BCBSM <strong>before</strong> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <strong>Step Therapy</strong>, 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</td>
</tr>
<tr>
<td><strong>Mandatory maximum allowable cost drugs</strong></td>
<td>If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the <strong>difference</strong> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <strong>plus</strong> your applicable copay regardless of whether you or your physician requests the brand name drug. <strong>Exception:</strong> If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. <strong>Note:</strong> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</td>
</tr>
</tbody>
</table>
Western Michigan Health Insurance Pool  
Group Number: 71565    Package Code(s): 068  
Section Code(s): 1020, 1120  
Hearing Care Coverage  
Effective Date: 01/01/2018  
Benefits-at-a-glance  

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

### Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Limitation</td>
<td>Once every 36 months</td>
</tr>
<tr>
<td>Audiometric Exam</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Hearing Aid Evaluation</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td></td>
<td>Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.</td>
</tr>
<tr>
<td>Hearing Aid Conformity Test</td>
<td>Covered - 100%</td>
</tr>
</tbody>
</table>
Western Michigan Health Insurance Pool
Group Number: 71565    Package Code(s): 008
Section Code(s): 1010, 1110
Versatile 4 PPO, RX25, Hearing
Effective Date: 01/01/2018
Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.
Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a “low access area” by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider’s charge.

### Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles - per calendar year</strong></td>
<td>$500 per member $1,000 per family</td>
<td>$1,000 per member $2,000 per family</td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td>$20 copay for:</td>
<td>No Copay</td>
</tr>
<tr>
<td>• Fixed Dollar Copays</td>
<td>Office visits</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>10% up to a maximum of:</td>
<td>30%</td>
</tr>
<tr>
<td>• Percent Coinsurance</td>
<td>$1,000 per member</td>
<td>Note: Services without a network are covered at the in-network level.</td>
</tr>
<tr>
<td></td>
<td>$2,000 per family</td>
<td></td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximum</strong></td>
<td>$3,000 per member $6,000 per family</td>
<td>$3,000 per member $6,000 per family</td>
</tr>
<tr>
<td></td>
<td>Includes Deductible, Coinsurance and Copays</td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime dollar maximum</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Care Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Exam - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Physical Related Test X-Rays, EKG and lab procedures</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>performed as part of the health maintenance exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Pap Smear Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mammography Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Contraceptive Methods and Counseling</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Endoscopic Exams one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 8 visits per calendar year, birth through 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits per calendar year, 13 months through 35 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 visits per calendar year, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations - pediatric and adult</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Physician Office Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Online Visits</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Note: Services are payable when rendered by American Well or BCBS providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Consultations</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Pre-Surgical Consultations</td>
<td>Covered - 100%</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>
### Emergency Medical Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Emergency Room Qualifying medical emergency</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Non-Emergency use of the Emergency Room</td>
<td>Covered - $25 copay then 90% after deductible</td>
<td>Covered - $25 copay then 70% after deductible</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Facility Professional</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Ambulance Services - Medically Necessary Transport</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
</tbody>
</table>

### Diagnostic Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI, MRA, PET and CAT Scans and Nuclear Medicine</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Laboratory &amp; Pathology</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>

### Maternity Services Provided by a Physician

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postnatal Care Visits</td>
<td>Covered - 100%</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>

### Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Inpatient Medical Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>

### Alternatives to Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
</tbody>
</table>

Limited to a maximum of 120 days per calendar year

### Surgical Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (includes related surgical services)</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after in-network deductible</td>
</tr>
<tr>
<td>Wisdom teeth extractions</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Sterilization - males only excludes reversal sterilization</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Sterilization - females only excludes reversal sterilization</td>
<td>Covered - 100%</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>
Human Organ Transplants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Organ Transplants</td>
<td>Covered - 100%</td>
<td>Not covered except in designated</td>
</tr>
<tr>
<td>In designated facilities only, when coordinated</td>
<td></td>
<td>facilities</td>
</tr>
<tr>
<td>through BCBSM Human Organ Transplant Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(800-242-3504)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney, Cornea, Bone Marrow and Skin</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>

Behavioral Health Care and Substance Abuse Treatment Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Inpatient Substance Abuse Treatment</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Care</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>• Online Behavioral Health Visits</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Treatment</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 90% after deductible</td>
</tr>
</tbody>
</table>

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Behavioral Analysis (ABA)</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Pre-authorization required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational and Speech therapy with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>an autism diagnosis is unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>

Other Covered Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Chiropractic Spinal Manipulation</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Allergy Testing and Therapy</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
</tbody>
</table>

Therapy Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Limited to a combined maximum of 60 visits per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 70% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.
Western Michigan Health Insurance Pool  
Group Number: 71565    Package Code(s): 008  
Section Code(s): 1010, 1110  
Prescription Drugs  
Effective Date: 01/01/2018  
Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

### Member’s responsibility (copays and coinsurance amounts)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| Retail - 30 day supply | $10 copay - Generic drugs  
|          | $40 copay - Brand drugs  
|          | $0 copay – OTC drugs  
|          | (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children’s Claritin, Claritin RediTabs and Claritin-D)  
|          | Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member’s copay. |
| Mail Order - 90 day supply | $20 copay - Generic drugs  
|          | $80 copay - Brand drugs |
| Specialty Drugs – 30 day supply Retail and Mail Order | $10 copay - Generic drugs  
|          | $40 copay - Brand drugs |
|          | Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill. |
| Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA | Covered - 100% |
| Oral and Injectable Contraceptives Retail and Mail Order | Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance |
| Additional Services |  
| Smoking Cessation Drugs | Covered |
| Weight Loss Drugs | Covered |
| Impotency Drugs | Covered |
| Infertility Drugs | Covered |
| Diabetic Supplies | Not Covered |

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
### Features of your prescription drug plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization/step therapy</td>
<td>A process that requires a physician to obtain approval from BCBSM <strong>before</strong> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <strong>Step Therapy</strong>, 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.</td>
</tr>
<tr>
<td>Mandatory maximum allowable cost drugs</td>
<td>If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST 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 <strong>plus</strong> your applicable copay regardless of whether you or your physician requests the brand name drug. <strong>Exception:</strong> If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. <strong>Note:</strong> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</td>
</tr>
</tbody>
</table>
Western Michigan Health Insurance Pool
Group Number: 71565  Package Code(s): 008
Section Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 01/01/2018
Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

**Covered services**

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Limitation</td>
<td>Once every 36 months</td>
</tr>
<tr>
<td>Audiometric Exam</td>
<td>Covered – 100%</td>
</tr>
<tr>
<td>Hearing Aid Evaluation</td>
<td>Covered – 100%</td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>Covered – 100%</td>
</tr>
<tr>
<td>Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.</td>
<td></td>
</tr>
<tr>
<td>Hearing Aid Conformity Test</td>
<td>Covered – 100%</td>
</tr>
</tbody>
</table>
Western Michigan Health Insurance Pool
Group Number: 71565    Package Code(s): 112
Section Code(s): 1020, 1120
PPO - CB1000, RX44, Hearing
Effective Date: 01/01/2018
Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.
### Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles - per calendar year</td>
<td>$1,000 per member $2,000 per family</td>
<td>$2,000 per member $4,000 per family</td>
</tr>
<tr>
<td>Copays</td>
<td>$20 copay for: • Office visits</td>
<td>No Copay</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Note:</strong> Services without a network are covered at the in-network level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual out-of-pocket maximums</td>
<td>$3,000 per member $6,000 per family</td>
<td>$4,000 per member $8,000 per family</td>
</tr>
<tr>
<td></td>
<td>Includes Deductible, Coinsurance and Copays</td>
<td>Includes Coinsurance</td>
</tr>
<tr>
<td>Lifetime dollar maximum</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Care Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Exam - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Pap Smear Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mammography Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Contraceptive Methods and Counseling</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Endoscopic Exams - one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 8 visits per calendar year, birth through 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits per calendar year, 13 months through 35 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 visits per calendar year, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations - pediatric and adult</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Physician Office Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Online Visits</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Note: Services are payable when rendered by American Well or BCBS providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Consultations</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Pre-Surgical Consultations</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>
### Emergency Medical Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Emergency Room</td>
<td>Covered - 100%</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Non-Emergency use of the Emergency Room</td>
<td>Covered - 100% after $25 copay</td>
<td>Covered - 100% after $25 copay</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Facility</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Professional</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Ambulance Services - Medically Necessary Transport</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
</tbody>
</table>

### Diagnostic Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI, MRA, PET and CAT Scans and Nuclear Medicine</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Laboratory &amp; Pathology</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

### Maternity Services Provided by a Physician

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postnatal Care Visits</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

### Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Inpatient Medical Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

### Alternatives to Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>Covered - 100%</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 120 days per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Surgical Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (includes related surgical services)</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after in-network deductible</td>
</tr>
<tr>
<td>Wisdom teeth extractions</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Sterilization - males only excludes reversal sterilization</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Sterilization - females only excludes reversal sterilization</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>
## Human Organ Transplants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Organ Transplants</td>
<td>Covered - 100%</td>
<td>Not covered except in designated facilities</td>
</tr>
<tr>
<td>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney, Cornea, Bone Marrow and Skin</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

## Behavioral Health Care and Substance Abuse Treatment Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Inpatient Substance Abuse Treatment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Care</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>• Online Behavioral Health Visits</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Treatment</td>
<td>Covered - 100% after $20 copay</td>
<td>Covered - 90% after deductible</td>
</tr>
</tbody>
</table>

## Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Behavioral Analysis (ABA)</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Pre-authorization required</td>
<td>Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.</td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational and Speech therapy with an autism diagnosis is unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

## Other Covered Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Chiropractic Spinal Manipulation</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 90% after deductible</td>
</tr>
<tr>
<td>Allergy Testing and Therapy</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

## Therapy Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a combined maximum of 60 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.
Western Michigan Health Insurance Pool  
Group Number: 71565   Package Code(s): 112  
Section Code(s): 1020, 1120  
Prescription Drugs  
Effective Date: 01/01/2018  
Benefits-at-a-glance

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 BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

<table>
<thead>
<tr>
<th>Member's responsibility (copays and coinsurance amounts)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
</tr>
<tr>
<td>Retail - 30 day supply</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Mail Order - 90 day supply</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Specialty Drugs – 30 day supply</td>
</tr>
<tr>
<td>Retail and Mail Order</td>
</tr>
<tr>
<td>Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.</td>
</tr>
<tr>
<td>Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA</td>
</tr>
<tr>
<td>Oral and Injectable Contraceptives</td>
</tr>
<tr>
<td>Retail and Mail Order</td>
</tr>
<tr>
<td>Additional Services</td>
</tr>
<tr>
<td>Smoking Cessation Drugs</td>
</tr>
<tr>
<td>Weight Loss Drugs</td>
</tr>
<tr>
<td>Impotency Drugs</td>
</tr>
<tr>
<td>Infertility Drugs</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
</tr>
</tbody>
</table>

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
### Features of your prescription drug plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior authorization/step therapy</strong></td>
<td>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. <strong>Step Therapy</strong>, 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</td>
</tr>
<tr>
<td><strong>Mandatory maximum allowable cost drugs</strong></td>
<td>If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST 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 copay regardless of whether you or your physician requests the brand name drug. <strong>Exception:</strong> If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. <strong>Note:</strong> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</td>
</tr>
</tbody>
</table>
Western Michigan Health Insurance Pool  
Group Number: 71565  Package Code(s): 112  
Section Code(s): 1020, 1120  
Hearing Care Coverage  
Effective Date: 01/01/2018  
Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

<table>
<thead>
<tr>
<th>Covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be payable, hearing care benefits must be received from a participating provider and in the order listed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Limitation</td>
<td>Once every 36 months</td>
</tr>
<tr>
<td>Audiometric Exam</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Hearing Aid Evaluation</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Hearing Aid Conformity Test</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td></td>
<td>Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.</td>
</tr>
</tbody>
</table>
Western Michigan Health Insurance Pool
Group Number: 71565    Package Code(s): 036, 037
Section Code(s): 3000, 3100, 3300, 3400
PPO - Flexible Blue 2, RX6
Effective Date: 01/01/2018

Benefits-at-a-glance

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 BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.
Member’s responsibility (deductibles, copays, coinsurance and dollar maximums)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles - per calendar year</strong></td>
<td>$1,350 per member</td>
<td>$2,700 per member</td>
</tr>
<tr>
<td>The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.</td>
<td>$2,700 per family</td>
<td>$5,400 per family</td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximums</strong></td>
<td>$2,300 per member</td>
<td>$4,500 per member</td>
</tr>
<tr>
<td>The full family out of pocket maximum must be met before it is considered satisfied.</td>
<td>$4,600 per family</td>
<td>Includes Deductible, Coinsurance and Copays</td>
</tr>
<tr>
<td><strong>Lifetime dollar maximum</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

Preventive Care Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Maintenance Exam - one per calendar year</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Pap Smear Screening - one per calendar year</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Mammography Screening - one per calendar year</strong></td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td><strong>Contraceptive Methods and Counseling</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Prostate specific antigen (PSA) screening - one per calendar year</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Endoscopic Exams one per calendar year</strong></td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td><strong>Well Child Care</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 8 visits per calendar year, birth through 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits per calendar year, 13 months through 35 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 visits per calendar year, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations - pediatric and adult</strong></td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Physician Office Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits</strong></td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td><strong>Online Visits</strong></td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> Services are payable when rendered by American Well or BCBS providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Consultations</strong></td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td><strong>Pre-Surgical Consultations</strong></td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>
# Emergency Medical Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Emergency Room</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Qualified medical emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency use of the Emergency Room</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Ambulance Services - Medically Necessary Transport</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
</tbody>
</table>

# Diagnostic Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI, MRA, PET and CAT Scans and Nuclear Medicine</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Laboratory &amp; Pathology</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

# Maternity Services Provided by a Physician

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Care Visits</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Postnatal Care Visits</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

# Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Inpatient Medical Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

# Alternatives to Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Limited to a maximum of 90 days per calendar year</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
</tbody>
</table>

# Surgical Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (includes related surgical services)</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after in-network deductible</td>
</tr>
<tr>
<td>Wisdom teeth extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilization - males only excludes reversal sterilization</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Sterilization - females only excludes reversal sterilization</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

# G10252017 00004236189
## Human Organ Transplants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Organ Transplants</td>
<td>Covered - 100% after deductible</td>
<td>Not covered except in designated facilities</td>
</tr>
<tr>
<td>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney, Cornea, Bone Marrow and Skin</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

## Behavioral Health Care and Substance Abuse Treatment Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Care and Substance Abuse Treatment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Care and Substance Abuse Treatment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>• Online Behavioral Health Visits</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

## Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Behavioral Analysis (ABA)</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Pre-authorization required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational and Speech therapy with an autism diagnosis is unlimited</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

## Other Covered Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Chiropractic Spinal Manipulation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Allergy Testing and Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

## Therapy Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a combined maximum of 60 visits per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.
Western Michigan Health Insurance Pool  
**Group Number:** 71565    **Package Code(s):** 036, 037  
**Section Code(s):** 3000, 3100, 3300, 3400

**Prescription Drugs**  
**Effective Date:** 01/01/2018

**Benefits-at-a-glance**

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

### Member’s responsibility (copays and coinsurance amounts)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| **Deductible**                                 | $1,350 per individual  
                                          | $2,700 per family                                                       |
| **Retail - 30 day supply**                    | $10 copay after deductible – Generic drugs  
                                          | $40 copay after deductible – Brand drugs  
                                          | $0 copay after deductible – OTC drugs  
                                          | *(Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children’s Claritin, Claritin RediTabs and Claritin-D)*  
                                          | Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 80% of the approved amount, less the member’s copay. |
| **Mail Order - 90 day supply**                | $20 copay after deductible – Generic drugs  
                                          | $80 copay after deductible – Brand drugs                                 |
| **Specialty Drugs – 30 day supply** Retail and Mail Order | $10 copay after deductible – Generic drugs  
                                          | $40 copay after deductible – Brand drugs                                 |
| **Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA** | **Covered - 100%** |
| **Oral and Injectable Contraceptives Retail and Mail Order** | **Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance** |
| **Additional Services**                       |                                                                          |
| Smoking Cessation Drugs                       | Covered                                                                 |
| Weight Loss Drugs                             | Covered                                                                 |
| Impotency Drugs                               | Covered                                                                 |
| Infertility Drugs                             | Covered                                                                 |
| Diabetic Supplies                             | Not Covered                                                             |

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
### Features of your prescription drug plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior authorization/step therapy</strong></td>
<td>A process that requires a physician to obtain approval from BCBSM <em>before</em> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <strong>Step Therapy</strong>, 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</td>
</tr>
<tr>
<td><strong>Mandatory maximum allowable cost drugs</strong></td>
<td>If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST 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 copay regardless of whether you or your physician requests the brand name drug. <strong>Exception:</strong> If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. <strong>Note:</strong> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</td>
</tr>
</tbody>
</table>
Western Michigan Health Insurance Pool
Group Number: 71565    Package Code(s): 102, 103
Section Code(s): 3000, 3100
PPO - SB HSA Plan 2, RX42
Effective Date: 01/01/2018

Benefits-at-a-glance

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.
### Member’s responsibility (deductibles, copays, coinsurance and dollar maximums)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles - per calendar year</strong></td>
<td>$2,000 per member</td>
<td>$4,000 per member</td>
</tr>
<tr>
<td>The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.</td>
<td>$4,000 per family</td>
<td>$8,000 per family</td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Fixed Dollar Copays</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Percent Coinsurance</td>
<td></td>
<td>Note: Services without a network are covered at the in-network level.</td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximums</strong></td>
<td>$6,000 per member</td>
<td>$6,000 per member</td>
</tr>
<tr>
<td>The full family out of pocket maximum must be met before it is considered satisfied.</td>
<td>$6,000 per family</td>
<td>Includes Deductible, Coinsurance and Copays</td>
</tr>
<tr>
<td><strong>Lifetime dollar maximum</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Care Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Exam - beginning age 4; one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Pap Smear Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mammography Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Contraceptive Methods and Counseling</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Endoscopic Exams one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 8 visits per calendar year, birth through 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits per calendar year, 13 months through 35 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 visits per calendar year, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations - pediatric and adult</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Physician Office Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Online Visits</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Note: Services are payable when rendered by American Well or BCBS providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Consultations</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Pre-Surgical Consultations</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a “low access area” by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.
### Emergency Medical Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Emergency Room</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Qualified medical emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency use of the Emergency Room</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Ambulance Services - Medically Necessary Transport</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

### Diagnostic Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI, MRA, PET and CAT Scans and Nuclear Medicine</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Laboratory &amp; Pathology</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

### Maternity Services Provided by a Physician

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Care Visits</td>
<td>Covered - 100%</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Postnatal Care Visits</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

### Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Inpatient Medical Care</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

### Alternatives to Hospital Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to lifetime maximum of 360 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 120 days per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Surgical Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (includes related surgical services)</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Covered - 50% after deductible</td>
<td>Covered - 50% after deductible</td>
</tr>
<tr>
<td>Sterilization - males only excludes reversal sterilization</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Sterilization - females only excludes reversal sterilization</td>
<td>Covered - 100%</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>
### Human Organ Transplants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Organ Transplants</td>
<td>Covered - 100% after deductible</td>
<td>Not covered except in designated facilities</td>
</tr>
<tr>
<td>Kidney, Cornea, Bone Marrow and Skin</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)

### Behavioral Health Care and Substance Abuse Treatment Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Care and Substance Abuse Treatment</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Care and Substance Abuse Treatment • Online Behavioral Health Visits</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

### Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Behavioral Analysis (ABA) Pre-authorization required</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational and Speech therapy with an autism diagnosis is unlimited</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

### Other Covered Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per calendar year</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Allergy Testing and Therapy</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

### Therapy Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 60% after deductible</td>
</tr>
</tbody>
</table>

**Note:** The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.
Western Michigan Health Insurance Pool  
**Group Number:** 71565  **Package Code(s):** 102, 103  **Section Code(s):** 3000, 3100  
**Prescription Drugs**  
**Effective Date:** 01/01/2018  
**Benefits-at-a-glance**

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 BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

### Member’s responsibility (copays and coinsurance amounts)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$2,000 per individual&lt;br&gt;$4,000 per family</td>
</tr>
<tr>
<td><strong>Retail - 30 day supply</strong></td>
<td>$20 copay after deductible - Generic drugs&lt;br&gt;$40 copay after deductible - Preferred brand drugs&lt;br&gt;$80 copay after deductible - Non-Preferred brand drugs</td>
</tr>
<tr>
<td>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member’s copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order - 90 day supply</strong></td>
<td>$40 copay after deductible - Generic drugs&lt;br&gt;$80 copay after deductible - Preferred brand drugs&lt;br&gt;$160 copay after deductible - Non-Preferred brand drugs</td>
</tr>
<tr>
<td><strong>Specialty Drugs – 30 day supply</strong></td>
<td>$20 copay after deductible - Generic drugs&lt;br&gt;$40 copay after deductible - Preferred brand drugs&lt;br&gt;$80 copay after deductible - Non-Preferred brand drugs</td>
</tr>
<tr>
<td>Retail and Mail Order</td>
<td>Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.</td>
</tr>
<tr>
<td>Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td><strong>Oral and Injectable Contraceptives</strong></td>
<td>Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance</td>
</tr>
<tr>
<td>Retail and Mail Order</td>
<td></td>
</tr>
<tr>
<td><strong>Additional Services</strong></td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation Drugs</td>
<td>Covered</td>
</tr>
<tr>
<td>Weight Loss Drugs</td>
<td>Covered</td>
</tr>
<tr>
<td>Impotency Drugs</td>
<td>Covered</td>
</tr>
<tr>
<td>Infertility Drugs</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
<table>
<thead>
<tr>
<th>Features of your prescription drug plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior authorization/step therapy</strong></td>
</tr>
<tr>
<td><strong>Mandatory maximum allowable cost drugs</strong></td>
</tr>
</tbody>
</table>
**MESSA Dental Plan Benefit Highlights**

**MESSA Account:** Ferndale School District  
**Employee Group:** Transportation  
**Effective Date:** 3-1-18  
**Group/Subgroup:** 0963-0031

**Plan Guidelines**

MESSA dental plans are underwritten and administered by Delta Dental of Michigan, a non-profit dental care corporation known for its high quality dental programs. Delta Dental contracts with dentists throughout the U.S. to provide high quality care and 90% of Michigan dentists are in the Delta Dental provider network. MESSA members can easily locate Delta Dental contracting providers by visiting [www.messa.org](http://www.messa.org) and using the provider directory search provided by Delta Dental.

<table>
<thead>
<tr>
<th>Diagnostic &amp; Preventive Services</th>
<th>Basic Services</th>
<th>Major Services</th>
<th>Orthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>100%</strong></td>
<td><strong>75%</strong></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
</tbody>
</table>

- Oral Examination
- Prophylaxes
- Topical Fluoride*
- Brush Biopsy
- Emergency Palliative
- Two Cleanings in 12 Months

**RIDER**  
(If neither box below is checked, you do not have this coverage.)

- 3 Cleanings in 12 Months
- 4 Cleanings in 12 Months

*Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.

- Radiographs (x-rays)*
- Restorative
- Crowns**
- Oral Surgery
- Endodontic Services — treatment for diseased or damaged nerves.
- Periodontic Services — treatment for diseases of the gum and teeth-supporting structures.

* Bitewing x-rays are payable once in any period of 12 consecutive months. Full mouth panograph is payable once in 5 years.

** Payable once in any five-year period on the same tooth.

**RIDER**  
(If the box below is not checked, you do not have this coverage.)

- Sealants — payable on occlusal surface of first permanent molars for patients up to age nine and for second permanent molars for patients up to age 14 that are free from cavities and restorations.

- Procedures for the construction of fixed bridgework, endosteal implants, partial and complete dentures.
- Payable once in any 5 year period for the same appliances.

- Necessary treatment and procedures required for the correction of abnormal bite.
- Orthodontic exam, radiographs and extractions are covered under Diagnostic & Preventive Services and Basic Services.

**RIDER**  
(If the box below is not checked, you do not have this coverage.)

- Adult orthodontics: removes the age 19 restriction on Orthodontics coverage.

$1,000 annual maximum per person Diagnostic & Preventive Services, Basic Services, and Major Services  
$1,000 lifetime maximum per person Orthodontics

For a complete listing of exclusions and limitations that apply to the plan, refer to the Delta Dental of Michigan certificate booklet.
CERTIFICATE OF INSURANCE

GROUP LONG TERM DISABILITY INSURANCE

Ferndale Public Schools
Ferndale, Michigan
Transportation Employees
The Group Policy has been issued to the Policyowner. No coverage under the Group Policy is in effect until approved in writing by Madison National Life Insurance Company, Inc.

The Employer must apply for group long term disability insurance coverage under the Group Policy and join the Policyowner by submitting a completed Joinder Agreement and agreeing to pay premiums. The Group Policy contains numerous optional and variable provisions. The options and variables we have approved for the Employer’s coverage under the Group Policy are contained in the Joinder Agreement and the Certificate(s) of Coverage. Only those provisions of the Group Policy which appear in the Joinder Agreement and the Certificate(s) of Coverage will apply to the Employer’s coverage under the Group Policy. All provisions on this and the following pages are part of the Certificate of Coverage.

The Group Policy is on file and available for review at the main office of the Policyholder. The Certificate summarizes and explains the parts of the Group Policy that apply to you. This certificate is not an insurance policy. In the event of any conflict between the Group Policy and the Certificate, the Group Policy will control.

This Certificate replaces any other Certificates previously provided to you under the Group Policy.

Unless defined differently within a particular provision, the terms “you” and “your” mean the Eligible Person. “We”, “us” and “our” mean Madison National Life Insurance Company. Other defined terms appear with their initial letters capitalized. References to section headings appear in quotation marks.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

By

Larry R. Graber
President
### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHEDULE OF BENEFITS</td>
<td>3</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>5</td>
</tr>
<tr>
<td>I. INSURING CLAUSE</td>
<td>8</td>
</tr>
<tr>
<td>II. ELIGIBILITY FOR INSURANCE</td>
<td>8</td>
</tr>
<tr>
<td>III. BECOMING INSURED</td>
<td>8</td>
</tr>
<tr>
<td>IV. WAIVER OF PREMIUM</td>
<td>10</td>
</tr>
<tr>
<td>V. WHEN YOUR INSURANCE ENDS</td>
<td>10</td>
</tr>
<tr>
<td>VI. RULES FOR TRANSFER OF EMPLOYEES FROM PRIOR PLAN</td>
<td>11</td>
</tr>
<tr>
<td>VII. REINSTATEMENT OF COVERAGE</td>
<td>12</td>
</tr>
<tr>
<td>VIII. DEFINITION OF DISABILITY</td>
<td>12</td>
</tr>
<tr>
<td>IX. RECURRENT DISABILITY</td>
<td>13</td>
</tr>
<tr>
<td>X. WHEN LTD BENEFITS END</td>
<td>13</td>
</tr>
<tr>
<td>XI. PREDISABILITY EARNINGS</td>
<td>13</td>
</tr>
<tr>
<td>XII. LTD BENEFIT CALCULATION</td>
<td>14</td>
</tr>
<tr>
<td>XIII. DEDUCTIBLE INCOME</td>
<td>14</td>
</tr>
<tr>
<td>XIV. BENEFITS AFTER INSURANCE ENDS OR IS CHANGED</td>
<td>17</td>
</tr>
<tr>
<td>XV. EFFECT OF NEW DISABILITY</td>
<td>17</td>
</tr>
<tr>
<td>XVI. EXCLUSIONS</td>
<td>17</td>
</tr>
<tr>
<td>XVII. LIMITATIONS</td>
<td>18</td>
</tr>
<tr>
<td>XVIII. RESPONSIBILITIES OF DISABLED INSURED PERSONS</td>
<td>19</td>
</tr>
<tr>
<td>XIX. CLAIMS</td>
<td>20</td>
</tr>
<tr>
<td>XX. RIGHT TO REIMBURSEMENT</td>
<td>21</td>
</tr>
<tr>
<td>XXI. SUBROGATION</td>
<td>22</td>
</tr>
<tr>
<td>XXII. TIME LIMITS ON LEGAL ACTIONS</td>
<td>22</td>
</tr>
<tr>
<td>XXIII. INCONTESTABILITY PROVISIONS</td>
<td>23</td>
</tr>
<tr>
<td>XXIV. CLERICAL ERROR AND MISSTATEMENT</td>
<td>23</td>
</tr>
<tr>
<td>XXV. FRAUD</td>
<td>24</td>
</tr>
<tr>
<td>XXVI. TERMINATION OR AMENDMENT OF THE GROUP POLICY AND EMPLOYER COVERAGE</td>
<td>24</td>
</tr>
<tr>
<td>XXVII. MEDICAL PREMIUM EXPENSE BENEFIT</td>
<td>24</td>
</tr>
<tr>
<td>XXVIII. REHABILITATION BENEFIT</td>
<td>25</td>
</tr>
</tbody>
</table>
SCHEDULE OF BENEFITS

Employer(s): Ferndale Public Schools

Plan Number: 7775

Original Plan Effective Date: March 1, 2018

Eligible Class: Class 03: Transportation Employees

Employer Premium Contribution: 100%

Elimination Period: Greater of 90 consecutive calendar days or end of accumulated sick pay

Minimum Hourly Work Requirement: 20 hours per week

Waiting Period: 90 Calendar Days

Evidence of Insurability: Required for Late Enrollees, Increases and amounts exceeding the Guarantee Issue

Employee Eligibility Date: Upon completion of the Waiting Period

Minimum Participation Requirement: 100%

Leaves and Sabbaticals: Coverage with premium payment while on FMLA leave Coverage with premium payment for up to 12 months while on Paid Leave

Definition of Disability: Zero Day

Own Occupation Period: 24 months following the end of the Elimination Period

Any Occupation Period: From the end of the Own Occupation Period to the end of the Maximum Benefit Period

Recurrent Disability: 6 months

Predisability Earnings: Base pay plus Longevity Pay

Maximum Monthly Covered Salary: $7,500

LTD Benefit Percentage: 60%

Maximum Monthly Benefit: $4,500

Guarantee Issue: $4,500

Minimum Monthly Benefit: 5% of Gross LTD Benefit
Maximum Benefit Period:

<table>
<thead>
<tr>
<th>Age at Disablement</th>
<th>Benefit Duration*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to age 60</td>
<td>To age 65</td>
</tr>
<tr>
<td>60 - 65</td>
<td>5 years</td>
</tr>
<tr>
<td>66</td>
<td>4 years</td>
</tr>
<tr>
<td>67</td>
<td>3 years</td>
</tr>
<tr>
<td>68</td>
<td>2 years</td>
</tr>
<tr>
<td>69 or older</td>
<td>1 year</td>
</tr>
</tbody>
</table>

*To the later of: 1) the specified length of time as stated above, or 2) the day before attaining the Social Security Normal Retirement Age under the United States Social Security Act, as revised.

Work Incentive Period: First 12 months of Disability with Work Earnings

LTD Benefit Calculation: Standard – Non-Contract Day

Social Security Integration: Full Family

Freeze Type: General Freeze

Mental Disorder Limitation: 24 Months unless hospital confined

Substance Abuse Limitation: 24 Months unless hospital confined

Claim Payment Method: Monthly

Medical Premium Expense Benefit: Included – Payable to the Employer

Rehabilitation Benefit: Included

GLDI-C400-(12/06)
DEFINITIONS

Active Work and Actively at Work are defined in Section II.

Any Occupation means any job for which you are qualified by education, training, or experience regardless of whether you are working in that or another occupation.

Contributory means that you pay all or a portion of the premium for insurance.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. Where required, we will obtain prior state approval of the new index.

Deductible Income is defined in Section XIII.

Disability and Disabled are defined in Section VIII.

Eligible Class means an employment classification defined by the Employer and specified in the “Schedule of Benefits”. You must be a member of an Eligible Class in order to be eligible for insurance under the Group Policy.

Eligible Person is defined in Section II.

Elimination Period means the period of time that you must be continuously Disabled before LTD Benefits become payable. No LTD Benefits are payable during the Elimination Period. Your Elimination Period is specified in the “Schedule of Benefits”.

Employee is defined in Section II.

Employer means an employer (including approved affiliates and subsidiaries) participating in Schools Insurance Fund of Wisconsin and to which we have assigned a Plan Number and issued a Joinder Agreement.

Evidence of Insurability is defined in Section III.

Group Policy with respect to the Policyowner means the group LTD insurance policy issued by us to the Policyowner. Group Policy with respect to an Employer means only those provisions of the Group Policy, including the options and variables requested by the Employer, that we have approved for that Employer with respect to its eligible employees. The Employer’s coverage under the Group Policy is described in the Joinder Agreement provided by us to the Employer and identified by the Plan Number.

Gross LTD Benefit is defined in Section XII.

Guarantee Issue is the amount of coverage provided, up to the Maximum Monthly Benefit, which is not subject to Evidence of Insurability.

Hospital means a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Rest homes, nursing homes, convalescent homes, homes for the aged and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals.

Indexed Predisability Earnings means your Predisability Earnings adjusted annually by the rate of increase in the CPI-W. During the first year of Disability, Indexed Predisability Earnings are the same as the Predisability Earnings. Thereafter, your Indexed Predisability Earnings are determined on each anniversary of your Disability using the above method. The maximum adjustment in any year is 7%. If the rate of the CPI-W decreases, your Indexed Predisability Earnings may reduce accordingly; however, such adjustments will never reduce your Indexed Predisability Earnings below the original amount.
Injury means a bodily injury that is the direct result of an accident, that is not related to any other cause, and which in and of itself results in your Disability within 90 days. Benefits will be payable to you only if the Injury occurs while you are insured under the Group Policy.

Insured Person means an Eligible Person whose coverage has become effective under the Group Policy.

Joinder Agreement means the document entered into between the Policyowner, the Employer and us describing the coverage requested by the Employer with respect to its Employees, which has been approved by us and assigned a Plan Number.

Late Enrollee means an Employee who applies for coverage under the Group Policy more than 31 days after becoming an Eligible Person.

LTD means long term disability.

LTD Benefit means the net benefit payment due to you after deductions are applied to your Gross LTD Benefit as provided for under the Group Policy. Your LTD Benefit is calculated under Section XIII.

Material Duties is defined in Section II.

Maximum Benefit Period means the longest period for which LTD Benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins at the end of the Elimination Period. No LTD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. Your Maximum Benefit Period is specified in the “Schedule of Benefits”.

Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome listed in the latest edition of American Psychiatric Association Diagnostic and Statistical Manual or the International Classification of Disease.

Noncontributory means the Employer pays the entire premium for insurance.

Own Occupation means the occupation you routinely perform for the Employer at the time Disability begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

Physical Disease means a physical disease entity or process that produces structural or functional changes in the body as diagnosed by a Physician. Physical Disease includes Pregnancy.

Physician means a licensed medical professional under the laws of a state of the United States of America, acting within the scope of such license, who is permitted by law to prescribe medications and practice independent of supervision.

For the purpose of this Group Policy, Physician will not include you or your Spouse, or the brother, sister, parent or child of either an Insured Person or an Insured Person’s Spouse.

Plan Effective Date means the date on which the Group Policy (with respect to the Employer) becomes effective.

Plan Number means the number used by us to reference an Employer and the terms of coverage specified under that Employer’s Joinder Agreement.

Policyowner means Schools Insurance Fund of Wisconsin.

Predisability Earnings is defined in Section XI.
Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means an Employer’s group long term disability insurance plan in effect on the day immediately preceding the Plan Effective Date under this Group Policy.

Proof of Loss is defined in Section XIX.

Regular Care of a Physician means:
1. that you personally visit a Physician as frequently as is medically required according to standard medical practice, but in no event less than annually, to effectively manage and treat your disabling condition(s);
2. that your Physician is rendering appropriate treatment and care for the disabling condition(s) which conform(s) with standard medical practice and is the most appropriate for the disabling condition(s), according to standard medical practice; and
3. that you are complying with all aspects of the treatment plan prescribed by the Physician.

Retirement Date means the earlier of:
1. the date you retire as defined by your Employer;
2. the date you become eligible to receive retirement benefits under any pension plan to which the Employer contributes, or
3. the date you become eligible to receive retirement benefits under any state or federal retirement plan or under social security law.

Spouse means a person to whom you are legally married and from whom you are not legally separated.

Substance Abuse means a condition listed in the latest edition of American Psychiatric Association Diagnostic and Statistical Manual or the International Classification of Disease within a classification category or code including but not limited to 291, 292, 303, 304 or 305.

Waiting Period is defined in Section II and the “Schedule of Benefits”.

Work Earnings means your gross monthly earnings from work performed while Disabled.

If you are paid in a lump sum or on a basis other than monthly, we will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, we will use a reasonable one.

In determining your Work Earnings, we:
1. will use the financial accounting method you use for income tax purposes, if you use that method on a consistent basis;
2. will not be limited to the taxable income you report to the Internal Revenue Service;
3. may ignore expenses under section 179 of the IRC as a deduction from your gross earnings;
4. may ignore depreciation as a deduction from your gross earnings;
5. may adjust the financial information you give us in order to clearly reflect your Work Earnings.

If we determine that your earnings vary substantially from month to month, we may determine Work Earnings by averaging your earnings over the most recent 12 month period. During the Own Occupation Period, you will no longer be Disabled when your average Work Earnings over the last 12 month period equal or exceed 80% of your Indexed Predisability Earnings, or when you are capable of earning 80% or more of your Indexed Predisability Earnings. During the Any Occupation Period, you will no longer be Disabled when your average Work Earnings over the last 12 month period equal or exceed 80% of your Indexed Predisability Earnings, or when you are capable of earning 80% or more of your Indexed Predisability Earnings.
I. INSURING CLAUSE

A. If you become Disabled while insured under the Group Policy, we will pay LTD Benefits according to the terms of your Employer’s coverage under the Group Policy, after we receive satisfactory Proof of Loss.

II. ELIGIBILITY FOR INSURANCE

A. To be eligible for insurance under the Group Policy, you must be an Eligible Person. An Eligible Person is an Employee who has met the following requirements:

1. You must be an Employee. Employee means an individual who works for the Employer as a member of an Eligible Class who is reported on the Employer’s records for Social Security and tax withholding purposes.

2. You must be a citizen or legal resident of the United States or Canada, and you must reside in the United States or Canada;

3. You must be Actively at Work and capable of sustained Active Work on the effective date of your coverage and on the effective date of any subsequent increase in LTD coverage because of an Eligible Class of Group Policy change.

   a) Active Work and Actively at Work mean performing all the Material Duties of your Own Occupation at your Employer’s usual place of business, and satisfying the Minimum Hourly Work Requirement. Actively at Work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of Active Work on those days.

   b) Minimum Hourly Work Requirement means the work hours over a given time period that are required of you by your Employer in order to be eligible for coverage. Your Minimum Hourly Work Requirement is specified in the Schedule of Benefits.

   c) Material Duties means the duties generally required by employers in the national economy of those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will working an average of more than 40 hours per week be considered a Material Duty.

4. You cannot be a temporary or seasonal employee, full-time member of the armed forces of any country, leased employee or independent contractor.

5. You must satisfy your Waiting Period. Waiting Period means the period of time that you must be Actively at Work as an Employee before your coverage may become effective. Your Waiting Period is specified in the “Schedule of Benefits”.

III. BECOMING INSURED

A. To become an Insured Person under the Group Policy, you must be an Eligible Person and meet the following requirements as each may apply:

1. If Evidence of Insurability is required, you must provide such Evidence of Insurability and be approved for coverage by us. The Schedule of Benefits specifies when Evidence of Insurability is required.

2. Evidence of Insurability.

   a) Providing Evidence of Insurability means that an applicant must:
(1) complete and sign our Evidence of Insurability application and return the original application to us no later than 60 days from the date of signing; and
(2) authorize us to obtain information about the applicant’s health; and
(3) undergo a physical examination, if required by us, which may include diagnostic testing; and
(4) provide any additional information about the applicant’s insurability that we may reasonably require.

b) If you, your Spouse or your dependents are required to provide Evidence of Insurability, you will be responsible for all costs associated with providing Evidence of Insurability.

c) In each case where Evidence of Insurability is required, we base our decision whether to approve coverage on the information provided during the underwriting process. If we learn that the information relied on to approve coverage was incorrect, or that relevant information was omitted, we may retroactively rescind coverage and deny claims.

3. If the insurance you wish to obtain is Contributory insurance, you must apply in writing and remit the required premiums.

B. Effective Date of Your Insurance

1. Initial Enrollment
   a) Noncontributory insurance not subject to Evidence of Insurability, or which is subject to Evidence of Insurability and has been approved by us, becomes effective on the date you become an Eligible Person. If, however, you initially waive participation in such coverage and then later wish to participate, you will be treated as a Late Enrollee, subject to Evidence of Insurability.

   b) Contributory insurance subject to Evidence of Insurability becomes effective on the first day of the month immediately following the month in which your Evidence of Insurability is approved by us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

   c) Contributory insurance not subject to Evidence of Insurability. Provided that you apply prior to, or within 31 days of becoming an Eligible Person, Contributory insurance not subject to Evidence of Insurability becomes effective on the date you become an Eligible Person. If you do not apply for such coverage prior to, or within 31 days of becoming an Eligible Person and subsequently wish to obtain coverage, you will be a Late Enrollee, subject to Evidence of Insurability.

2. Increases in Existing Coverage and Late Enrollee Applications
   a) Where Evidence of Insurability is required, increases of existing coverage and Late Enrollee applications become effective on the first day of the month immediately following the month in which your Evidence of Insurability is approved by us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

   b) Where Evidence of Insurability is not required, an increase of existing coverage becomes effective on the date that you become eligible for such coverage.

3. If you are incapable of sustained Active Work due to a Disability on the day before the scheduled effective date of your insurance, such insurance will not become effective until the day after you are capable of sustained Active Work and complete one day of Active Work as an Eligible Person.

GLDI-C800-(12/06)
IV. WAIVER OF PREMIUM

A. Premium payments are required during the Elimination Period. However, payment of premium is waived while LTD Benefits are payable. Upon your return to Active Work, premium payments will again be payable.

V. WHEN YOUR INSURANCE ENDS
This provision applies to you if you are not Disabled.

A. Except as otherwise provided for under this section, your coverage will cease on the earliest of the following dates:
   1. the date your Employer's coverage under the Group Policy terminates;
   2. the date you cease to be an Eligible Person;
   3. the date that your premium payment is not paid when required;
   4. the date you become eligible for coverage under another group long-term disability policy;
   5. if you are a contract employee not returning to work as an Eligible Person the next contract year, the earlier of the following:
      a) the date you become employed with another employer;
      b) your Retirement Date;
      c) expiration of the current contract year;
   6. your Retirement Date.

B. Approved FMLA Leave of Absence - Contributory or Noncontributory Coverage
   1. If you are on a FMLA leave, coverage will continue until the later of the leave period required by the Federal Family and Medical Leave Act of 1993, as amended, or the leave period required by applicable state law, provided that:
      a) the FMLA leave is approved in advance by the Employer and such approval includes documentation of the beginning and ending dates of the leave and the amount of your covered salary. Such documentation about your leave must be available to Us at Our request;
      b) FMLA leaves of absence and the right to continue coverage during FMLA leaves are available to all Employees in the same Eligible Class under the Group Policy; and
      c) the Employer remits the required premium for coverage.
   2. The Elimination Period can be satisfied and benefits may be payable during a FMLA leave subject to all other contract provisions. The benefit will be based on the lesser of your earnings in effect on your last full day of Active Work prior to the leave, or the salary for which premium was paid.

C. Paid Leave of Absence. If you are on a paid leave of absence, coverage will continue subject to the following:
   1. Noncontributory coverage
      a) Coverage will continue provided that:
         (1) the paid leave of absence is approved in advance by the Employer and such approval includes documentation of the beginning and ending dates of the leave and the amount of your covered salary. Such documentation about your paid leave of absence must be made available to Us at Our request; and
         (2) paid leaves of absence and the right to continue coverage during paid leaves are available to all Employees in the same Eligible Class under the Group Policy; and
         (3) the Employer remits the required premium for coverage.
      b) The Elimination Period can be satisfied during a paid leave of absence, but benefits will not begin until the later of the end of the Elimination Period or the date the paid leave was scheduled to end. In the event a benefit is payable, it will be based on the lesser of your earnings in effect on your last full day of Active Work prior to the paid leave of absence, or the salary for which premium was paid.
c) Unless you return to active, eligible status on or before the date the paid leave of absence is scheduled to end, coverage extended during a paid leave of absence will terminate on the earlier of the date the paid leave of absence is scheduled to end or 12 months from the date the paid leave of absence began.

2. Contributory Coverage
   a) Coverage will continue provided that:
      (1) the paid leave of absence is approved in advance by the Employer and such approval includes documentation of the beginning and ending dates of the leave and the amount of your covered salary. Such documentation about your paid leave of absence must be made available to Us at Our request; and
      (2) paid leaves of absence and the right to continue coverage during paid leaves of absence are available to all Employees in the same Eligible Class under the Group Policy; and
      (3) you continue to pay the required premium to the Employer without interruption and the Employer continues to remit premium to us on your behalf.

   b) The Elimination Period can be satisfied during a paid leave of absence, but benefits will not begin until the later of the end of the Elimination Period or the date the paid leave was scheduled to end. In the event a benefit is payable, it will be based on the lesser of your earnings in effect on your last full day of Active Work prior to the paid leave of absence, or the salary for which premium was paid.

c) Unless you return to active, eligible status on or before the date the paid leave of absence is scheduled to end, coverage extended during a paid leave of absence will terminate on the earlier of the date the paid leave of absence is scheduled to end, or 12 months from the date the paid leave of absence began or the date you fail to pay premium as required.

d) If you choose not to continue coverage or your coverage terminates during a paid leave of absence and you subsequently wish to obtain coverage, you will be treated as a Late Enrollee and be required to provide Evidence of Insurability.

GLDI-C1000-(12/06)

VI. RULES FOR TRANSFER OF EMPLOYEES FROM PRIOR PLAN

A. If you were eligible for insurance and insured under the Prior Plan on the day before the Plan Effective Date, you can become insured on the Plan Effective Date without meeting the Active Work requirement under Section II.A.3.

B. The LTD Benefit will be the lesser of the monthly benefit that would have been payable under the terms of the Prior Plan if it had remained in force, or the LTD Benefit as determined under the other provisions of this Group Policy. However, no benefits will be payable to you under the Group Policy if any benefits are payable to you under the Prior Plan.

C. If you were eligible for insurance under the Prior Plan for more than 31 days but were not insured under the Prior Plan, you must provide Evidence of Insurability and be approved by us to become insured.

GLDI-C1100-(12/06)
VII. REINSTATEMENT OF COVERAGE

A. If your coverage ends, you may become covered again as an Insured Person, subject to the following:

1. If you cease to be an Eligible Person and coverage ends, and then you return to Active Work with the Employer again within 3 months, the Waiting Period will be waived on the first day of your return to Active Work and you will not have to provide Evidence of Insurability.

2. If your coverage ends because you fail to make the required contribution while on an approved Family Medical Leave Act (FMLA) leave of absence, and then you return to Active Work and enroll for coverage within 31 days of the earlier of:
   a) the end of the period of leave you and your Employer agreed upon; or
   b) the end of the 12 week period following the date your leave began,
   then the Waiting Period will be waived and you will not have to provide Evidence of Insurability.

3. In all other cases, if your coverage ends because you fail to make the required contribution, you must provide Evidence of Insurability to become covered again.

4. In no event will insurance coverage be retroactive.

VIII. DEFINITION OF DISABILITY

A. **Disability or Disabled** means that during the Elimination Period and your Own Occupation Period you are, as a result of Physical Disease, Injury, Mental Disorder, Substance Abuse or Pregnancy, unable to perform one or more of the Material Duties of your Own Occupation, and, due to such inability, your Work Earnings are less than 80% of your Indexed Predisability Earnings, and you are incapable of earning 80% or more of your Indexed Predisability Earnings.

Your Work Earnings may be Deductible Income. See the “LTD Benefit Calculation” and “Deductible Income” sections.

B. After your Own Occupation Period ends, **Disability and Disabled** mean you are, as a result of Physical Disease, Injury, Mental Disorder, Substance Abuse or Pregnancy, unable to perform one or more of the Material Duties of Any Occupation, and, due to such inability, your Work Earnings are less than 80% of your Indexed Predisability Earnings, and you are incapable of earning 80% or more of your Indexed Predisability Earnings.

Your Work Earnings may be Deductible Income. See the “LTD Benefit Calculation” and “Deductible Income” sections.

C. Loss of License or Certification. For an Insured Person whose occupation requires a license, a restriction or loss of license does not, in itself, constitute a Disability.

D. Preventive Measures. Your inability to perform any of your Material Duties because of preventive treatments or other preventive measures does not, by itself, constitute a Disability.

E. Your Own Occupation Period and Any Occupation Period are specified in the Schedule of Benefits.
IX. RECURRENT DISABILITY

A. If you return to work for your Employer from a Disability for which benefits were payable under the Group Policy and then become Disabled again due to the same or related cause, we will treat the separate periods of Disability as one period of continuous Disability, provided you are continuously insured under the Group Policy during the period of recovery and the period of recovery does not exceed 6 months. Benefits resume on the date your Disability recurs.

B. If you return to work for your Employer from a Disability covered under the Group Policy and then become Disabled again due to an unrelated cause, we will treat the subsequent Disability as a new claim, subject to all of the terms of the Group Policy.

C. If you return to work for your Employer from a Disability covered under the Group Policy and then become Disabled again more than 6 months after you return to work, the subsequent Disability will be treated as a new claim, subject to all of the terms of the Group Policy.

D. For the purposes of this provision, if your occupation with the Employer does not allow you to be Actively at Work for the entire calendar year due to a seasonal or regularly scheduled employment break, we will consider you to have returned to work if you would have been able to return to work had work been regularly scheduled.

GLDI-C1500-(12/06)

X. WHEN LTD BENEFITS END

A. Your LTD Benefits end automatically on the earliest of the following:
   1. The date you are no longer Disabled;
   2. The date your Maximum Benefit Period ends;
   3. The date you die;
   4. The date you become eligible for coverage under any other group LTD plan under which you become insured through employment;
   5. The date you fail to provide satisfactory objective medical evidence of continued Disability;
   6. The date you fail to comply with our request to be examined by a Physician, other medical practitioner and/or a vocational or rehabilitation expert of our choice;
   7. The date you refuse to accept an accommodated position, offered by your Employer, which you are able to perform, whether it is in your Own Occupation or Any Occupation;
   8. The date at which you have resided outside of the United States or Canada for 6 months;
   9. The date you are confined in a penal or correctional institution or under house arrest;
   10. The date you fail to comply with any requirements set forth in Section XVIII, Responsibilities of Disabled Insureds;
   11. The date you are able to work and earn 80% of your Indexed Predisability Earnings but choose not to.

GLDI-C1600-(12/06)

XI. PREDISABILITY EARNINGS

A. Predisability Earnings means your earnings in effect on your last full day of Active Work prior to becoming Disabled. Unless otherwise specifically provided for under the Group Policy, any subsequent change in your earnings will not affect your Predisability Earnings.

B. Methods of Calculating Predisability Earnings

   1. Salaried Employees. Your monthly Predisability Earnings are equal to your annual Predisability Earnings divided by twelve.
2. Hourly Employees. If you are paid hourly, your monthly Predisability Earnings will be based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month, not to exceed 173.33 hours. If you do not have regular work hours, your monthly Predisability Earnings are based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months), not to exceed 173.33 hours.

C. Predisability Earnings includes the following:
   1. your base rate of pay;
   2. longevity pay.

D. Predisability Earnings does not include the following:
   1. commissions;
   2. bonuses;
   3. overtime pay;
   4. pay for extracurricular activities;
   5. extra duty pay;
   6. supplemental pay;
   7. shift differential;
   8. your Employer’s contributions to your health insurance premium;
   9. your Employer’s contributions to a Tax Sheltered Annuity (TSA);
   10. your Employer’s contributions on your behalf to any deferred compensation arrangement, pension plan, or other fringe benefits;
   11. any other extra compensation.

E. Notwithstanding Section A above, in no event will your monthly Predisability Earnings exceed either the monthly salary for which premiums have been paid or the Maximum Monthly Covered Salary.

XII. LTD BENEFIT CALCULATION

A. Your monthly Gross LTD Benefit is equal to the lesser of your monthly Predisability Earnings times the LTD Benefit Percentage, or the Maximum Monthly Benefit.

B. Your monthly LTD Benefit is calculated as follows:

   1. During the Work Incentive Period, Your LTD Benefit will be equal to your monthly Gross LTD Benefit minus monthly Deductible Income (subject to the Minimum Monthly Benefit);

   2. Upon expiration of the Work Incentive Period, your LTD Benefit will be calculated as follows (subject to the Minimum Monthly Benefit):\((A \div B) \times C\), where:
      \(A = \text{monthly Indexed Predisability Earnings minus Work Earnings for that same period.}\)
      \(B = \text{monthly Indexed Predisability Earnings.}\)
      \(C = \text{monthly Gross LTD Benefit minus monthly Deductible Income (exclusive of Work Earnings).}\)

XIII. DEDUCTIBLE INCOME

A. Your Gross LTD Benefit will always be reduced by Deductible Income which is available to you or which you are eligible to receive as a result of your Disability, whether or not you apply for and receive such payments or benefits. The Deductible Income that we will subtract from your Gross LTD Benefit is listed below.
B. To receive the full measure of income under the Group Policy, you must apply for all Deductible Income for which you may be eligible as soon as you are entitled to such benefits. If you do not apply for and actively pursue in good faith all Deductible Income for which you may be eligible, we may make our own conclusion as to whether you are entitled to those benefits. If we reasonably and in good faith determine that you are entitled to Deductible Income, we will estimate the amount of those benefits and reduce the Gross LTD Benefit by that estimated amount as of the date on which we deem you were eligible to receive Deductible Income. Integration of the estimated amount of Deductible Income that we have determined is available to you will continue until you provide us with proof that you have filed the appropriate application(s) and continue to actively pursue Deductible Income.

Each month we will determine your LTD Benefit using the Deductible Income for the same monthly period, even if you receive the Deductible Income in another month.

C. If you are paid Deductible Income in a lump sum, we will use the period of time to which the Deductible Income applies. If no period of time is stated, we will make a reasonable estimate.

D. We will not estimate the amount of Deductible Income nor reduce your Gross LTD Benefit by any amounts for which applications or administrative appeals for Deductible Income are pending, provided that you:
   1. apply for in good faith and pursue to our satisfaction all Deductible Income for which we determine you might be eligible;
   2. designate, at our request, an agent endorsed by us as your representative in the application process and cooperate with that representative at all stages of the application process;
   3. keep us informed on a timely basis of the status of all applications for Deductible Income;
   4. sign a Reimbursement Agreement; and
   5. pursue administrative appeals of Deductible Income denials.

E. **Deductible Income** includes the following:
   1. Sick pay (including donated amounts and paid time off);
   2. Annual or personal leave pay, severance pay, or other salary continuation payable to you by your Employer;
   3. Work Earnings as follows:
      a) During the First 12 months of Disability with Work Earnings (the “Work Incentive Period”), if the total amount of your Gross LTD Benefit plus the amount you receive from Work Earnings exceeds 100% of your Predisability Earnings, the amount in excess of 100% of your Predisability Earnings will be included in Deductible Income;
      b) Upon expiration of the Work Incentive Period, your Work Earnings will be offset as provided in Section XII.
   4. Any amount you receive or are eligible to receive because of your Disability under any of the following:
      a) a Workers’ Compensation Law to the extent we, at our discretion, determine that these amounts are of the general character as payments provided under the Group Policy for Disability;
      b) the Jones Act;
c) Maritime Doctrine of Maintenance, Wages or Cure;
d) Longshoremen’s and Harbor Worker’s Act;
e) any similar act or law;

5. The amount that you, your Spouse and children receive or are eligible to receive because of your disability or retirement benefits under:
   a) the United States Social Security Act;
   b) the Canada Pension Plan;
   c) the Quebec Pension Plan;
   d) the Railroad Retirement Act; or
   e) any similar Plan or Act;

   Benefits your Spouse or a child receive or are eligible to receive because of your Disability are Deductible Income regardless of the marital status, custody, or place of residence;

6. Any amount you receive or are eligible to receive because of your Disability under any state disability income benefit law or similar law;

7. Retirement plans
   a) Any disability or retirement benefits you receive or are eligible to receive because of your Disability under your Employer’s retirement plan, including a public employee retirement system, a state teacher retirement system, or a plan arranged and maintained by a union or employee association for the benefit of its members;
   b) If any of these plans has two or more payment options, the option which comes closest to providing you a monthly income to age 65 with no survivor benefit will be used to determine Deductible Income;
   c) Your and your Employer’s contributions will be considered as distributed simultaneously throughout your lifetime, regardless of how funds are distributed from the retirement plan;

8. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law;

9. Any amount you receive or are eligible to receive from or on behalf of a third party because of your Disability, whether by judgment, settlement or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as Deductible Income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees;

10. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed;

11. Any amount you receive under any “no fault” motor vehicle plan

12. Any amount you receive or are eligible to receive because of your Disability under any group insurance coverage.

F. Deductible Income does not include the following:

1. Any cost of living increases in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income.

2. Reimbursement for hospital, medical or surgical expense;
3. Reasonable attorneys’ fees incurred in connection with a claim for Deductible Income;

4. Benefits from any individual disability insurance policy;

5. Early retirement benefits under the Federal Social Security Act which are not received;

6. Group credit or mortgage disability insurance benefits;

7. Accelerated benefits paid under a life insurance policy;

8. Under your Employer’s retirement plan, any amount you could have received upon termination of employment without being disabled or retired;

9. Benefits from the following:
   a) Profit sharing plan;
   b) Thrift or savings plan;
   c) Deferred compensation plan;
   d) Plan under IRC Section 401(k), 408(k), or 457;
   e) Individual Retirement Account (IRA);
   f) Tax Sheltered Annuity (TSA) under IRC Section 403(b);
   g) Stock ownership plan;
   h) Keogh (HR-10) plan;
   i) Retirement plan under a professional service corporation with respect to principals.

GLDI-C1900-(12/06)

**XIV. BENEFITS AFTER INSURANCE ENDS OR IS CHANGED**

A. During each period of continuous Disability, we will pay LTD Benefits according to the terms of your Employer’s coverage under the Group Policy in effect on the date you become Disabled. Your right to receive LTD Benefits will not be affected by:
   1. any amendment to the Group Policy or your Employer’s coverage under the Group Policy that is effective after you become Disabled.
   2. termination of the Group Policy or your Employer’s coverage under the Group Policy after you become Disabled.

GLDI-C2000-(12/06)

**XV. EFFECT OF NEW DISABILITY**

A. If a period of Disability is extended by a new cause while LTD Benefits are payable, LTD Benefits will continue while you remain Disabled, subject to the following:
   1. LTD Benefits will not continue beyond the end of the original Maximum Benefit Period;
   2. The “Exclusions” and “Limitations” sections will apply to the new cause of Disability.

GLDI-C2100-(12/06)

**XVI. EXCLUSIONS**

A. War. You are not covered for a Disability caused or contributed to by War or any act of War. War means a state or period of declared or undeclared war whether civil or international, any substantial armed conflict with organized forces of a military nature between nations, states or parties, or acts of terrorism.
B. Criminal Conduct. You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault, battery, or any other crime. You are not covered for a Disability caused as a result of your engaging in an illegal activity, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

C. Military Leave. You are not covered for a Disability that occurs during any military leave for active duty, including training duty, the National Guard and Coast Guard, or any active or reserve component of the military forces of any state or country.

D. Imprisonment. No LTD Benefits will be paid for any period of Disability when you are, for any reason, confined in a penal or correctional institution or under house arrest.

E. Intentionally Self-Inflicted Injury-Suicide. You are not covered for a Disability caused or contributed to by an intentionally self-inflicted injury or attempted suicide, while sane or insane.

GLDI-C2200-(12/06)

XVII. LIMITATIONS

A. Mental Disorders and Substance Abuse
   1. LTD Benefit payments based on a Mental Disorder or Substance Abuse are limited to 24 months for each period of continuous Disability. This is not a separate maximum for each such condition, but a combined maximum for Mental Disorders or Substance Abuse, either separate or combined.

   2. If your Disability is caused by Substance Abuse, you must be participating in an available rehabilitative program recommended by a Physician. An available rehabilitative program is a Substance Abuse program available to you through either: (i) another group plan of your employer (such as an Employee Assistance Program or Medical Plan); or (ii) services generally available to the public through local community services at no or minimal cost to you. Except as otherwise provided for below, LTD benefits will not be made beyond the earlier of the following:
      a) the date on which LTD Benefits have been paid for the maximum duration specified in subsections A1 and A3 or under the Maximum Benefit Period;
      b) the date you are no longer participating in the rehabilitative program;
      c) the date you refuse to participate in an available rehabilitative program; or
      d) the date you complete the rehabilitative program.

   3. Exception to 24 month limitation. If at the end of that 24 month period, you are confined in a Hospital, or other facility qualified to provide necessary care and treatment for Mental Disorders or Substance Abuse, for at least one day immediately following that 24 month period, LTD Benefits will continue during such confinement, not to exceed the Maximum Benefit Period.

B. Foreign Residency. Payment of LTD Benefits is limited to 6 months for each period of continuous Disability while you reside outside of the United States or Canada.

C. Payment Limit. In no event will the LTD Benefit plus Deductible Income plus Work Earnings exceed 100% of Predisability Earnings. In the event your LTD Benefit plus Deductible Income plus Work Earnings exceeds 100% of Predisability Earnings, the LTD Benefit will be reduced by the amount in excess of 100% of Predisability Earnings.

GLDI-C2300-(12/06)
A. Your Obligations During A Period Of Disability

1. You must make a good faith effort to recover from, or reduce the severity of, your Disability and the resulting loss of income, or you will forfeit benefits. The Group Policy requires you to take a variety of actions in this regard, including, but not limited to, the following:

   a) You must accept any position within a broad definition of Own Occupation that you can perform and which your Employer or another employer makes available during the Own Occupation Period regardless of whether the compensation for such work is less than your Predisability Earnings. The income earned will be treated as Work Earnings.

   b) You must arrange for and use the Regular Care of a Physician. In addition, you must pursue any reasonable medical procedure or treatment that would likely improve your condition or end your Disability, and that does not pose unreasonable risks.

   c) You must submit periodic evidence from your Physician that substantiates, to our satisfaction, that you remain Disabled. This required evidence includes, but is not limited to, objective medical and/or psychiatric evidence from a Physician that confirms your Disability. Subjective complaints alone will not be considered conclusive evidence of a Disability. The attending Physician must be able to provide objective medical evidence to support his/her opinion as to why you are not able to perform the Material Duties of your Own Occupation or Any Occupation. You must obtain and provide this information at your own expense.

   d) Where they exist, you must engage in appropriate medical and/or occupational rehabilitation programs that are reasonably expected to enable you to return to work. You must notify us when you participate in such a program.

   e) You must appeal denials of Deductible Income and actively pursue such appeals in good faith.

   f) You must promptly provide us with all information that we reasonably decide is necessary to verify and administer your claim for benefits.

2. Return to Work Responsibility

   a) During the Own Occupation Period, no LTD Benefits will be paid for any period of Disability when you are able to work in your Own Occupation and able to earn at least 80% of your Indexed Predisability Earnings, but you elect not to work.

   b) During the Any Occupation Period, no LTD Benefits will be paid for any period of Disability when you are able to work in Any Occupation and are able to earn at least 80% of your Indexed Predisability Earnings, but elect not to work.

   c) Any earnings you receive from work you perform, or that you could receive if you worked as much as you are able to considering your Disability, that are less than 100% of your Indexed Predisability Earnings will be treated as Work Earnings.

3. Duty to Furnish Information. To receive benefits under the Group Policy, you must authorize and direct medical care providers and sources of earnings or Deductible Income to provide us with all information and records that we reasonably determine to be relevant to the determination of benefits or eligibility for benefits. We do not pay fees charged for submitting this information to us. Any such costs will be your responsibility.
B. Our Right to Examine. We may require you to be examined by a Physician, other medical practitioner and/or vocational expert of our choice, in addition to your obligation to be under the Regular Care of a Physician as specified above. In such case, we will pay for the additional examination. You must cooperate fully with the Physician, medical practitioner or vocational expert and give full effort to such examinations. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Company representative.

C. Insured Person’s Failure to Comply
1. We have the right to suspend benefits during any portion of a Disability in which you fail to comply with any of the requirements set forth in this Certificate.

2. We have the further right to terminate irrevocably all further benefits under the Group Policy when benefits have been suspended for a period of 6 consecutive months due to your failure to comply with any of the requirements of the Group Policy.

GLDI-C2400-(12/06)

XIX. CLAIMS

A. Notice of Claim
1. Written notice of claim should be given to us within 30 days of the date the Elimination Period ends, if that is possible. If that is not possible, you must notify us as soon as it is reasonably possible to do so.

2. When we receive a written notice of claim, we will send you our claim forms for filing Proof of Loss. If you do not receive the forms within 15 days after written notice of claim is sent, you can send us written Proof of Loss without waiting for the forms.

B. Proof of Loss
1. Proof of Loss means all the information necessary to determine that a loss occurred:
   a) for which the Group Policy provides benefits; and
   b) which is not subject to any exclusions; and
   c) which meets all other conditions for benefits.

2. Written Proof of Loss must be furnished to us at our home office no later than 90 days after the end of the Elimination Period. If it is not possible to give proof within this time limit, it must be given as soon as reasonably possible, but not later than one year following the end of the 90 day period. These limits will not apply while an Insured Person lacks legal capacity.

3. Any items we may reasonably require in support of a claim, such as completed claims statements and a signed authorization for us to obtain information including tax information, must be submitted at your expense. If the required documentation is not provided within 60 days after we mail our request, your claim may be denied. No benefits will be paid until we receive Proof of Loss satisfactory to us.

C. Investigation of Claim
1. We may investigate a claim at any time.

2. At our expense, we may have you examined at reasonable intervals by specialists of our choice. We may deny or suspend benefits if you fail to attend an examination, give full effort or cooperate with the examiner.

D. Payment of Claims
1. We will pay LTD Benefits within 30 days after we receive satisfactory Proof of Loss, but not before satisfaction of the Elimination Period.
2. Claim Payment Method. LTD Benefit payments that you qualify for will be paid to you as specified in the “Schedule of Benefits”. Payments for partial weekly benefits will be pro-rated based on a 7 day week. Payments for partial monthly benefits will be pro-rated based on a 30 day month.

3. LTD Benefits payable at the time of your death will be paid to the person(s) receiving the “Survivor Benefit” if applicable. If no “Survivor Benefit” is paid, the unpaid LTD Benefits will be paid to your estate.

E. Notice of Adverse Decision on Claim
1. We will notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after we receive satisfactory Proof of Loss. This period may be extended by us for up to 30 days, provided that we determine that such an extension is necessary due to matters beyond our control, and provided that we notify you prior to the end of the initial 45 day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision.

2. If, prior to the end of the first 30 day extension period, we determine that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that we notify you prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which we expect to render a decision.

3. In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be given at least 45 days within which to provide the specified information.

4. If we deny any part of your claim, you will receive a written notice of denial containing the following:
   a) the reasons for our decision;
   b) reference to the provisions of the Group Policy on which our decision is based;
   c) a description of any additional information needed to support your claim;
   d) information concerning your right to a review of our decision.

F. Review Procedure
1. If all or part of a claim is denied, you may request a review. A request for a review must be in writing and received by us within 120 days after you receive notice of the denial.

2. You may send us written comments or other items to support the claim and may review any non-privileged information that relates to the request for review.

3. We will review the claim promptly after we receive the request. We will send you a notice of our decision within 45 days after we receive the request, unless special circumstances require an extension. If we determine that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the expiration of the initial 45 day period. In no event will such extension exceed a period of 60 days from the end of the initial period.

G. Assignment. The rights and benefits under the Group Policy are not assignable.

GLDI-C2500-(12/06)

XX. RIGHT TO REIMBURSEMENT

A. If we make benefit payments to you in excess of the amounts required by the provisions of this Group Policy or, if you receive retroactive benefits from any Deductible Income source for periods of time during which we paid benefits to you, you must reimburse us for any such excess, duplicate, or erroneous payments.
B. Before any LTD Benefits are paid to you, you must execute and deliver to us a Reimbursement Agreement, provided by us, setting forth specific terms of reimbursement.

C. Upon request, you must execute and deliver to us such documents as may be required, and do whatever else may be necessary, to secure our rights to recover any excess, duplicate, or erroneous payments.

D. You must reimburse us in a satisfactory and timely manner for any payments made to which you were not entitled under the terms of this Policy. Such reimbursement will be due and payable immediately upon our notification to you. At our option, subsequent payment of benefits or the refund of any premium owed to you by us may be reduced or applied by us directly toward such reimbursement obligation. If you delay in notifying us of your receipt of Deductible Income or in making reimbursement to us, we will have the right to charge interest at a reasonable rate on the delinquent amount owed to us.

E. Our acceptance of premium or other fees, or our providing or paying of benefits, does not constitute a waiver of our rights to enforce the provisions of this section in the future. The provisions of this section are in addition to, and not in lieu of, any other rights or remedies available to us at law or in equity.

F. The Minimum Monthly Benefit may be applied to recover an outstanding overpayment.

GLDI-C2600-(12/06)

XXI. SUBROGATION

A. If LTD Benefits are paid or payable to you under the Group Policy as the result of any act or omission of a third party, we will be subrogated to all rights of recovery you may have in respect to such act or omission. You must execute and deliver to us such instruments and papers as may be required and do whatever else is needed to secure such rights. You must avoid doing anything that would prejudice our rights of subrogation.

B. If you notify us before filing suit or settling your claim against such third party, the amount to which we are subrogated will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees. If suit or action is filed, we may record a notice of payments of LTD Benefits and such notice will constitute a lien on any judgment recovered.

C. If you or your legal representatives fail to bring suit or action promptly against such third party, we may institute such suit or action in our name or in your name. We are entitled to retain from any judgment recovered the amount of LTD Benefits paid or to be paid to you or on your behalf, together with our costs of recovery, including attorney fees. The remainder of such recovery, if any, will be paid to you or as the court may direct.

GLDI-C2700-(12/06)

XXII. TIME LIMITS ON LEGAL ACTIONS

A. No action at law or in equity may be brought until 60 days after we have received Proof of Loss. No such action may be brought more than three years after the earlier of the following:
   1. the date we receive Proof of Loss;
   2. the time within which Proof of Loss is required to be given.

GLDI-C2900-(12/06)
XXIII. INCONTESTABILITY PROVISIONS

A. Incontestability of Insurance
   1. Any statement made to obtain or to increase insurance is a representation and not a warranty.

   2. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of insurance unless:
      a) the insurance would not have been approved if we had known the truth; and
      b) we have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

   3. After insurance has been in effect for two years during the lifetime of the Insured Person, we will not use a misrepresentation as a basis for reducing or denying a claim, unless it was a fraudulent misrepresentation.

B. Incontestability of the Group Policy or Employer Coverage under the Group Policy
   1. Any statements made by the Policyowner to obtain the Group Policy or made by an Employer to obtain coverage under the Group Policy is a representation and not a warranty.

   2. No misrepresentation by the Policyowner or your Employer will be used as a basis for denying a claim, or for denying the validity of the Group Policy or your Employer’s coverage under the Group Policy unless:
      a) the Group Policy would not have been issued or your Employer’s coverage under the Group Policy would not have been approved if we had known the truth; and
      b) we have given the Policyowner or Employer a copy of a written instrument signed by the Policyowner or Employer which contains the misrepresentation.

   3. The validity of the Group Policy or your Employer’s coverage under the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

XXIV. CLERICAL ERROR AND MISSTATEMENT

A. Clerical Error
   1. Clerical error by us, the Policyowner, your Employer, or their respective employees or representatives will not:
      a) cause a person to become insured under the Group Policy or a provision of it.
      b) invalidate insurance otherwise validly in force.
      c) continue insurance otherwise validly terminated.
      d) cause an Employer to obtain coverage under the Group Policy or a provision of it.

   2. In the event that a clerical error results in an incorrect rate, we reserve the right to adjust the rate accordingly.

B. The payment of premium, by itself, will not obligate us to provide benefits to anyone who is not eligible for coverage under the Group Policy.

C. Your Employer acts on its own behalf as your agent, and not as our agent. Your Employer has no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

D. Misstatement of Age or Gender
   1. If the age or gender, or both, of a person has been misstated, we will make an equitable adjustment of premiums, benefits or both. The adjustment will be based on:
a) the amount of insurance based on the correct age and gender; and
b) the difference between the premiums paid and the premiums which would have been paid if the age and gender had been correctly stated.

GLDI-C3100-(12/06)

XXV. FRAUD

A. It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the Group Policy and recovery of any amounts we have paid.

GLDI-C3200-(12/06)

XXVI. TERMINATION OR AMENDMENT OF THE GROUP POLICY AND EMPLOYER COVERAGE

A. The Group Policy may be terminated, changed or amended in whole or in part by us or the Policyowner according to the terms of the Group Policy. Any such change or amendment may apply to current or future Employers and Eligible Persons covered under the Group Policy or to any separate classes or categories thereof. An Employer’s coverage under the Group Policy may be terminated, changed or amended in whole or in part by us or the Employer according to the terms of the Group Policy.

B. We may change the Group Policy and any Employer’s coverage under the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyowner’s or Employer’s consent.

C. We may terminate an Employer’s coverage on any premium due date by giving the Employer not less than 31 days advance notice. An Employer may terminate coverage under the Group Policy in whole, and may terminate insurance for any class or group of Eligible Persons, at any time by giving us advanced written notice at least 31 days prior to such termination. Insurance will terminate automatically for nonpayment of premium.

D. Benefits are limited to the terms of your Employer’s coverage under the Group Policy, including any valid amendments. No change or amendment of your Employer’s coverage will be valid unless it is approved in writing by one of our executive officers and delivered to your Employer. The Policyowner, your Employer and their respective employees or representatives have no right or authority to change or amend the Group Policy or your Employer’s coverage under the Group Policy or to waive any terms or provisions thereof without our signed, written approval.

GLDI-C3300-(12/06)

XXVII. MEDICAL PREMIUM EXPENSE BENEFIT

A. If you are receiving a LTD Benefit under the Group Policy, we will pay the Medical Premium Expense Benefit, subject to the below provisions.

B. Qualifications for Coverage
   1. You are an Insured Person and have met the following requirements under the Group Policy:
      a) You are Disabled;
      b) Such Disability has extended for the longer of 60 calendar days or the applicable Elimination Period; and
      c) You have been, and continue to be, under the Regular Care of a Physician during the period of Disability.
2. You must also be insured under a group medical benefit plan carried by the Employer until at least the day the Disability, described above, began.

C. Amount of Benefit. The amount of the Medical Premium Expense Benefit will be equal to the premium paid for the last full month of coverage, whether for individual or family coverage, held by you under the group medical benefit plan, prior to the date your Disability began, not to exceed $1,500. The amount of coverage under the group medical benefit plan that we will recognize will not exceed the amount in force on your last full day of Active Work prior to the start of Disability. The amount of medical premium must be shown on the monthly billing for you and must include both the participating Employer’s and the Employee’s portions of the premium. This Benefit will not be payable for any increase in premium cost or amounts of coverage becoming effective after the date of Disability.

D. Payment of Benefit
   1. If you meet the Qualifications for Coverage, payment will be made as follows:
      a) To establish evidence of your coverage and proof of the premium amount billed and paid, the Employer must submit to us, in a timely manner, a copy of the group medical benefit plan’s monthly billing as of the last full month prior to your date of Disability.
      b) The Medical Premium Expense Benefit will not become payable sooner than the day the Elimination Period ends and Disability benefits become payable to you.
      c) The Medical Premium Expense Benefit will then be paid retroactively to the 31st day of Disability.
         This may result in payment of the benefit for a part of the Elimination Period.

E. Termination of Benefit
   1. The Medical Premium Expense Benefit will terminate and payment under it will stop on the earliest of the following dates:
      a) The day your Disability benefits under the Group Policy end;
      b) The day your insurance coverage under the Group Policy ends, as described in the “When Your Insurance Ends” section.
      c) The day the 24th monthly Medical Premium Expense Benefit payment has become payable.

GLD-C5900-(12/06)

XXVIII. REHABILITATION BENEFIT

A. While you are Disabled, you may qualify to participate in a Rehabilitation Plan. Rehabilitation Plan means a written plan, program or course of medical treatment or vocational training or education that is intended to prepare you to return to work full time.

B. To participate in a Rehabilitation Plan, you must apply in a letter to us. The terms, conditions and objectives of the plan must be accepted by you and approved by us in advance. We have the sole discretion to evaluate, approve and/or terminate your Rehabilitation Plan at any time.

C. While you are participating in an approved Rehabilitation Plan, your LTD Benefit will be reduced by 50% of any income earned by you for work done under the Rehabilitation Plan. If the sum of your Gross LTD Benefit and Work Earnings exceeds 100% of Predisability Earnings, the excess will be included in Deductible Income. At no time will LTD Benefits be paid beyond the Maximum Benefit Period or be less than the Minimum Monthly Benefit.

GLD-C6300-(12/06)
AMENDMENT
TO THE
GROUP LONG TERM DISABILITY INSURANCE
CERTIFICATE OF COVERAGE

Employer: Ferndale Public Schools
Plan Number: 7775

Eligible Class: 03) Transportation Employees

This Amendment number 01 effective March 1, 2018 amends certain provisions of the Group Long Term Disability Insurance Certificate of Coverage as specified below. Provisions under this Amendment are subject to all the terms and conditions, limitations and exclusions of the Group Policy, unless otherwise stated herein.

1. The section entitled ‘XXVII. MEDICAL PREMIUM EXPENSE BENEFIT’ is hereby deleted in its entirety and replaced with the following:

‘XXVII. MEDICAL PREMIUM EXPENSE BENEFIT

A. If you are receiving a LTD Benefit under the Group Policy, we will pay the Medical Premium Expense Benefit, subject to the below provisions.

B. Qualifications for Coverage

1. You are an Insured Person and have met the following requirements under the Group Policy:
   a) You are Disabled;
   b) Such Disability has extended for the longer of 90 calendar days or the applicable Elimination Period; and
   c) You have been, and continue to be, under the Regular Care of a Physician during the period of Disability.

2. You must also be insured under a group medical benefit plan carried by the Employer.

C. Amount of Benefit. The amount of the Medical Premium Expense Benefit, whether for individual or family coverage, held by you under the group medical benefit plan, will be equal to the lesser of the following:

1. The medical premium amount for the last full month of coverage prior to the date your Disability began;

2. The medical premium amount for the current month;

3. $1,500.

The amount of medical premium must be shown on the monthly billing for you and must include both the participating Employer’s and the Employee’s portions of the premium. This Benefit will not be payable for any increase in premium cost or amounts of coverage becoming effective after the date of Disability.
D. Payment of Benefit

1. If you meet the Qualifications for Coverage, payment will be made as follows:
   
a) To establish evidence of your coverage and proof of the premium amount billed and paid, the Employer must submit to us, in a timely manner, a copy of the group medical benefit plan’s monthly billing as of the last full month prior to your date of Disability, and each month thereafter or as requested by MNL.

b) The Medical Premium Expense Benefit will not become payable sooner than the day the Elimination Period ends and Disability benefits become payable to you.

c) The Medical Premium Expense Benefit will then be paid retroactively to the 31st day of Disability. This may result in payment of the benefit for a part of the Elimination Period.

E. Termination of Benefit

1. The Medical Premium Expense Benefit will terminate and payment under it will stop on the earliest of the following dates:
   
a) The day your Disability benefits under the Group Policy end;

b) The day your insurance coverage under the Group Policy ends, as described in the “When Your Insurance Ends” section.

c) The day the 24th monthly Medical Premium Expense Benefit payment has become payable.

d) The date you are no longer covered under the Employer’s group medical benefit plan.
CERTIFICATE OF INSURANCE

GROUP TERM LIFE INSURANCE

Ferndale Public Schools
Ferndale, Michigan
Transportation Employees
GROUP TERM LIFE INSURANCE  
CERTIFICATE OF INSURANCE

PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance (hereinafter referred to as “Certificate”) is evidence of insurance provided under the Group Policy issued to the Group Policyholder (hereinafter referred to as “Policyholder”). This Certificate describes the essential features of such insurance.

Madison National Life Insurance Company, Inc., in performing its obligations under the Group Policy, is acting only as a life insurer with respect to the Group Policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other federal or state laws.

No coverage under the Group Policy is in effect until approved in writing by Us and issued and delivered to the Policyholder. All terms, conditions and other provisions of the Group Policy are governed by the laws of the state in which the Policyholder is located. All provisions on this and the following pages are part of this Certificate. The Group Policy is on file and available for review at the main office of the Policyholder.

The President and Secretary of Madison National Life Insurance Company, Inc witness this Certificate:

Larry R. Graber  
President

Loan Nisser  
Secretary

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHEDULE OF BENEFITS</td>
<td>3</td>
</tr>
<tr>
<td>I.   DEFINITIONS</td>
<td>4</td>
</tr>
<tr>
<td>II.  ELIGIBILITY FOR INSURANCE</td>
<td>6</td>
</tr>
<tr>
<td>III. BECOMING INSURED</td>
<td>6</td>
</tr>
<tr>
<td>IV.  WHEN COVERAGE ENDS</td>
<td>8</td>
</tr>
<tr>
<td>V.   LIFE INSURANCE - WAIVER OF PREMIUM BENEFIT</td>
<td>9</td>
</tr>
<tr>
<td>VI.  LIFE INSURANCE - LIVING BENEFIT</td>
<td>11</td>
</tr>
<tr>
<td>VII. LIFE INSURANCE CONVERSION BENEFIT</td>
<td>12</td>
</tr>
<tr>
<td>VIII. ACCIDENTAL DEATH &amp; DISMEMBERMENT INSURANCE</td>
<td>12</td>
</tr>
<tr>
<td>IX.  CLAIMS PROVISIONS</td>
<td>13</td>
</tr>
<tr>
<td>X.   GENERAL PROVISIONS</td>
<td>15</td>
</tr>
</tbody>
</table>
SCHEDULE OF BENEFITS

A. Administrative
1. Employer: Ferndale Public Schools
2. Plan Number: 35185
3. Initial Plan Effective Date: March 1, 2018
4. Evidence of Insurability Requirements: Applies to Late Enrollees, Increases in Benefits and Amounts over Guarantee Issue Amounts
5. Eligible Class: 03 Transportation Employees
6. Minimum Hourly Work Requirement: 20 hours per week
7. Waiting Period for Insurance Coverage: 90 calendar days
8. New Employee Eligibility Date: Upon completion of the Waiting Period
9. Leaves / Layoffs:
   Coverage with premium payment while on FMLA leave
   Coverage with premium payment for up to 12 months while on Paid Leave
10. Employee Premium Contribution
    Employee Basic Insurance: 0%
11. Participation Requirements
    Employee Basic Insurance: 100%
12. Insurance Reduction Schedule
    Employee Basic Insurance: Basic Life and AD&D Insurance does not reduce and terminates at retirement

B. Basic Life Insurance
   Employee Basic Life: $25,000
   Guarantee Issue: $25,000

C. Additional Benefits
1. Conversion of Insurance Benefit: Included
2. Waiver of Premium Benefit: Included
3. Living Benefit: Included

D. Accidental Death and Dismemberment (AD&D) Insurance
1. Basic AD&D Insurance
   Employee Basic AD&D Insurance: Equal to Basic Life amount
   Guarantee Issue: Equal to Basic Life amount
I. DEFINITIONS

**Active Work** and **Actively at Work** are defined in the “Eligibility for Insurance” section.

**Annual Salary:** Your current salary or wage from your Employer for the previous twelve months. Annual Salary does not include extra pay, annuity contributions, commissions, bonuses, overtime pay or any other extra compensation.

**Contributory** means that You pay all or a portion of the premium for insurance.

**Disabled** or **Disability** means that as a result of Physical Disease or Injury, you are unable to perform with reasonable continuity a majority of the material duties of any occupation for which you are qualified by education, training and experience, and you are under the Regular Care and Attendance of a Physician.

**Eligible Class** means an employment classification defined by the Employer and specified in the “Schedule of Benefits.” You must be a member of an Eligible Class in order to be eligible for insurance under the Group Policy.

**Eligible Dependent** is defined in the “Eligibility for Insurance” section.

**Eligible Employee** is defined in the “Eligibility for Insurance” section.

**Employee** is defined in the “Eligibility for Insurance” section.

**Employer** means an Employer (including approved affiliates and subsidiaries) participating in the Policyholder Trust to whom We have assigned a Plan Number and issued a Joinder Agreement.

**Evidence of Insurability**

1. Providing Evidence of Insurability means that a person applying for coverage under the Group Policy must:
   a) complete and sign Our Evidence of Insurability application and return the original application to Us. The application must be received by Us no later than 60 days from the date of signing; and
   b) authorize Us to obtain information about the applicant’s health; and
   c) undergo a physical examination, if required by Us, which may include diagnostic testing; and
   d) provide any additional information about the applicant’s insurability that We may reasonably require.

2. If any applicant is required to provide Evidence of Insurability, the applicant will be responsible for all costs associated with providing Evidence of Insurability.

3. In each case where Evidence of Insurability is required, We base Our decision whether to approve coverage on the information provided during the underwriting process. If We learn that the information relied on to approve coverage was incorrect, or that relevant information was omitted, We may retroactively rescind coverage and deny claims.

**Group Policy (Policy)** means the group insurance Policy issued by Us to the Policyholder under a specified Plan Number.

**Guarantee Issue** is the amount of coverage provided which is not subject to Evidence of Insurability.

**Hospital** means a legally operated Facility providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians, but not including rest homes, nursing homes, convalescent homes, homes for the aged and facilities primarily affording custodial, educational, or rehabilitative care.

**Injury:** Bodily Injury due to an Accident which: (1) results directly and independently of disease, bodily infirmity or any other causes; (2) solely, directly and independently of all other causes results in medical expense; (3) occurs after the effective date of the Insured Person's coverage; and (4) occurs while the Insured Person's coverage is in
force. All Injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

**Insured Person** means an Eligible Employee, Eligible Dependent or Eligible Retiree whose coverage is in effect under the Group Policy.

**Joinder Agreement** means the document entered into between the Policyholder and the Employer describing the coverage requested by the Employer with respect to its Employees, which has been approved by Us and assigned a Plan Number.

**Late Enrollee** means an Employee or Dependent who applies for coverage under the Group Policy more than 31 days after becoming an Eligible Employee or Eligible Dependent.

**Limiting Age** means the Child age(s) shown in the definition of Child in the Eligibility for Insurance section.

**Mental Disorder** means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress related abnormality, disorder, disturbance, dysfunction or syndrome listed in the latest edition of the American Psychiatric Association Diagnostic and Statistical Manual or the International Classification of Disease.

**Noncontributory** means the Employer pays the entire premium for insurance.

**Physical Disease** means a Physical Disease entity or process that produces structural or functional changes in the body as diagnosed by a Physician. Physical Disease includes pregnancy and Mental Disorder.

**Physician** means a licensed medical professional under the laws of a state of the United States of America, acting within the scope of such license, who is permitted by law to prescribe medications and practice independent of supervision.

For the purpose of this Group Policy, Physician will not include the Insured Person’s Spouse, parent, brother, sister, or Child, including these members of a Spouse’s family.

**Plan Effective Date** means the date on which the Group Policy, with respect to the Employer, becomes effective.

**Plan Number** means the number used by Us to reference an Employer and the terms of coverage specified under the Group Policy and Joinder Agreement.

**Prior Plan** means the Employer’s group life insurance plan in effect on the day immediately preceding the Plan Effective Date.

**Proof of Loss** is defined in the “Claims Provisions” section.

**Regular Care and Attendance** means observation and treatment by a Physician as required by current standards of medicine for the Injury or Physical Disease causing a Disability, but in any event not less than one such observation per year.

**Retire** and **Retirement Date** means the earlier of:

1. the date You Retire as such term is defined by Your Employer;
2. the date You receive or become eligible to receive, as defined by the Employer, retirement benefits under any pension plan to which the Employer contributes,
3. or the date You receive or become eligible to receive retirement benefits under, and as defined by, any state or federal retirement plan or under the Social Security Act or Railroad Retirement Act.
4. the date You reach the age defined in the “Schedule of Benefits”.
You and Your means the Eligible Employee.

Waiting Period for Insurance Coverage is defined in the “Eligibility for Insurance” and “Schedule of Benefits”.

We, Us and Our means Madison National Life Insurance Company, Inc.

II. ELIGIBILITY FOR INSURANCE

A. Employee Life Insurance Eligibility.
   1. Employee Basic Life Insurance. To be eligible for Employee Basic Life Insurance under the Group Policy, You must satisfy the following requirements:
      
      a) You must be an Eligible Employee.
         (1) Employee means an individual who works for the Employer as a member of an Eligible Class and who is reported on the Employer’s records for Social Security and tax withholding purposes.

      b) You must be a citizen or legal resident of the United States of America or one of its territories.

      c) You must be Actively at Work and capable of sustained Active Work.
         (1) Active Work and Actively at Work mean working at Your Employer’s usual place of business, and satisfying the Minimum Hourly Work Requirement. Actively at Work will include regularly scheduled days off, holidays, or vacation days, so long as You are capable of sustained Active Work on those days.
         (2) Minimum Hourly Work Requirement means the work hours over a specified time period that are required of You by Your Employer in order to be eligible for coverage. Your Minimum Hourly Work Requirement is specified in the “Schedule of Benefits”.
         (3) The Active Work requirement is waived during the time You are approved for benefits under the “Waiver of Premium Benefit” section.

      d) You must have satisfied Your Waiting Period for Insurance Coverage.
         (1) Waiting Period means the period of time that You must be Actively at Work as an Employee for Your coverage to become effective. Your Waiting Period is specified in the “Schedule of Benefits”.

      e) You cannot be a member of more than one Eligible Class.

      f) You cannot be a temporary or seasonal Eligible Employee, full-time member of the armed forces of any country, leased Eligible Employee, or independent contractor.

III. BECOMING INSURED

A. To become an Insured Person under the Group Policy, an applicant must meet the following requirements as each may apply:
   1. If Evidence of Insurability is required, the applicant must provide such Evidence of Insurability and be approved for coverage by Us. The “Schedule of Benefits” specifies when Evidence of Insurability is required.

   2. If the insurance is Contributory insurance, the applicant must apply in writing and remit the required premiums.

B. Effective Dates
   1. Employee’s Initial Enrollment
      a. Noncontributory insurance not subject to Evidence of Insurability or which is subject to Evidence of Insurability and has been approved by Us, becomes effective on the date You become an Eligible
Employee, or as specified by your Employer. However, if You initially waive participation in such coverage and then later wish to participate, applications for Noncontributory insurance will be subject to Evidence of Insurability and will become effective as shown below.

b. Contributory insurance subject to Evidence of Insurability, and Late Enrollee applications for coverage, become effective on the first day of the month immediately following the month in which the Evidence of Insurability is approved by Us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

c. Contributory insurance not subject to Evidence of Insurability, if You apply prior to, or within 31 calendar days commencing on, the date You become an Eligible Employee, Contributory insurance not subject to Evidence of Insurability becomes effective on the date You become an Eligible Employee. If You do not apply for Contributory insurance prior to, or within 31 days of becoming an Eligible Employee and subsequently wish to obtain such coverage, Evidence of Insurability will be required and Your coverage will become effective as provided in subsection b above.

2. Increases in Insurance

a. Evidence of Insurability Required. An increase of insurance that is subject to Evidence of Insurability becomes effective on the first day of the month immediately following the month in which the Evidence of Insurability is approved by Us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

b. Evidence of Insurability Not Required. An increase of insurance that is not subject to Evidence of Insurability becomes effective as follows:
   1) Based on change in Your classification, age or earnings on the date of such change;

3. Decreases in Insurance

a. A decrease in life insurance based on a change in Your classification, earnings, age or Your Dependent’s age, becomes effective on the date of the change.

b. Any other decrease in insurance becomes effective on the first day of the calendar month following the date Your Employer receives Your written request for the decrease, except that if such event occurs on the first day of a month, the decrease in coverage becomes effective on that day.

4. Delayed Effective Date. If You are incapable of sustained Active Work due to Injury or Physical Disease on the day before the scheduled effective date of Your insurance or the effective date of a change in Your insurance, such insurance will not become effective until the day after You are capable of sustained Active Work and complete one day of Active Work as an Eligible Employee.

5. If Your coverage ends, You may become covered again, subject to the following:

a. If Your coverage ends because You fail to make the required contribution while on an approved Family Medical Leave of absence, and then You return to Active Work and enroll for coverage within 31 days of the earlier of a) the end of the period of leave You and Your Employer agreed upon, or b) the end of the 12-week period following the date Your leave began, then the Waiting Period will be waived. Coverage is limited to what You had in effect prior to coverage ending or the coverage that is now available for Your Class, as determined by Us.

b. In all other cases, if Your coverage ends because You fail to make the required contribution, You must provide Evidence of Insurability to become covered again.

c. In no event will insurance coverage be retroactive.

d. If You cease to be an Eligible Employee and coverage ends, and then You return to Active Work with the Employer again within 3 months, the Waiting Period will be waived on the first day of Your return to Active Work.
IV. WHEN COVERAGE ENDS

A. Except as otherwise provided for under this Certificate, coverage will cease on the earliest of the following to occur:
   1. the date the Group Policy terminates or the date Your Employer’s coverage under the Group Policy terminates;
   2. the date You cease to be an Eligible Employee;
   3. if premium is not paid when required, the last day of the period for which premium was paid;
   4. the date You become eligible for coverage as an employee under another group term life insurance policy;
   5. if You are a contract Eligible Employee not returning to work as an Eligible Employee the next contract year, the earlier of the following:
      a) the date You become employed with another employer;
      b) Your Retirement Date, unless You become insured for Retiree Life Insurance under the Group Policy;
      c) expiration of the current contract year;
   6. Your Retirement Date, unless You become insured for Retiree Life Insurance under the Group Policy.
   7. for AD&D coverage, the earlier of the date Your corresponding life insurance ends, the date you are no longer Actively at Work, the date Your Waiver of Premium Benefit begins or Your Retirement Date.

B. Approved FMLA Leave of Absence – Contributory or Noncontributory Coverage
   1. With regard to the Federal Family and Medical Leave Act (FMLA) of 1993, as amended, the Employer and Employee must be eligible for FMLA in order to receive it. If You are on an approved FMLA leave, coverage will continue until the later of the leave period required by FMLA or the leave period required by applicable state law, provided that:
      a) The FMLA leave is approved in advance by the Employer and such approval includes documentation of the beginning and ending dates of the FMLA leave; and
      b) The documentation of the advance approval of the FMLA leave beginning and end dates is available to Us at Our request; and
      c) FMLA leaves of absence and the right to continue coverage during FMLA leaves are available to all Employees in the same Eligible Class under the Group Policy; and
      d) the Employer remits the required premium for coverage.

C. Paid Leave of Absence. If You are on a paid leave of absence, coverage will continue subject to the following:
   1. Noncontributory coverage
      a) Coverage will continue provided that:
         (1) The paid leave of absence is approved in advance by the Employer and such approval includes documentation of the beginning and ending dates of the paid leave of absence; and
         (2) The documentation of the advance approval of the paid leave of absence beginning and end dates is available to Us at Our request; and
         (3) paid leaves of absence and the right to continue coverage during paid leaves are available to all Employees in the same Eligible Class under the Group Policy; and
         (4) the Employer remits the required premium for coverage.
      b) Unless You return to active, eligible status on or before the date the paid leave of absence is scheduled to end, coverage extended during a paid leave of absence will terminate on the earlier of:
         (1) the date the paid leave of absence is scheduled to end;
         (2) 12 months from the date the paid leave of absence began; or
         (3) upon termination of employment with the Employer.
   2. Contributory Coverage
      a) Coverage will continue provided that:
         (1) The paid leave of absence is approved in advance by the Employer and such approval includes documentation of the beginning and ending dates of the paid leave of absence; and
         (2) The documentation of the advance approval of the paid leave of absence beginning and end dates is available to Us at Our request; and
(3) paid leaves of absence and the right to continue coverage during paid leaves of absence are available to all Employees in the same Eligible Class under the Group Policy; and
(4) You continue to pay the required premium to the Employer without interruption and the Employer continues to remit premium to Us on Your behalf.

b) Unless You return to active, eligible status on or before the date the paid leave of absence is scheduled to end, coverage extended during a paid leave of absence will terminate on the earlier of:
(1) the date the paid leave of absence is scheduled to end;
(2) 12 months from the date the paid leave of absence began;
(3) upon termination of employment with the Employer; or
(4) the date You fail to pay the premium as required.

c) If You choose not to continue coverage or Your coverage terminates during a paid leave of absence and You subsequently wish to obtain coverage, You will be treated as a Late Enrollee and be required to provide Evidence of Insurability.

D. Termination or Amendment of the Group Policy and Employer Coverage
1. The Group Policy may be terminated, changed or amended in whole or in part by Us or the Policyholder according to the terms of the Group Policy. Any such change or amendment may apply to current or future Employers and eligible persons covered under the Group Policy or to any separate classes or categories thereof. An Employer’s coverage under the Group Policy may be terminated, changed or amended in whole or in part by Us or the Employer according to the terms of the Group Policy.

2. We may change the Group Policy and any Employer’s coverage under the Group Policy in whole or in part: (i) when any change or clarification in law or governmental regulation affects Our obligations under the Group Policy, or (ii) with the Policyholder’s or Employer’s consent.

3. We may terminate an Employer’s coverage on any premium due date by giving the Employer not less than 60 days advance notice. An Employer may terminate coverage under the Group Policy in whole, and may terminate insurance for any class or group of eligible persons, at any time by giving Us advanced written notice at least 60 days prior to such termination. Insurance will terminate automatically for nonpayment of premium.

4. Benefits are limited to the terms of Your Employer’s coverage under the Group Policy, including any valid amendments. No change or amendment of Your Employer’s coverage under the Group Policy will be valid unless it is approved in writing by one of Our executive officers and delivered to Your Employer. The Policyholder, Your Employer and their Eligible Employees or representatives have no right or authority to change or amend the Group Policy or Your Employer’s coverage under the Group Policy or to waive any terms or provisions thereof without Our signed, written approval.

V. LIFE INSURANCE - WAIVER OF PREMIUM BENEFIT

A. Waiver of Premium Definitions
1. Elimination Period means the period of 6 months beginning on the date You become Disabled.
2. Life Insurance under this Waiver of Premium Benefit means all of the Life Insurance, as listed in the Schedule of Benefits, in force under the Group Policy on the day before the day You become Disabled.
3. Proof of Disability means documented clinical findings that prove that You are Disabled.

B. Waiver of Premium does not apply to AD&D Insurance.

C. Your Life Insurance will be continued as provided for under this section without payment of premium, if all of the following conditions are met:
1. You become Disabled prior to age 60 while insured under the Group Policy;
2. You remain Disabled without interruption for the duration of the Elimination Period;
3. You provide Us with written notice of Your Disability within 30 days after the end of Your Elimination Period;
4. You provide Us with satisfactory written Proof of Disability within 12 months from the last day of the Elimination Period;
5. Your claim is approved by Us.

D. When the Waiver of Premium Benefit Begins. If You qualify and are approved for the Waiver of Premium Benefit, Your premium will be waived beginning on the first day of the month immediately following the end of Your Elimination Period.

E. When Waiver of Premium Ends. Waiver of Premium ends on the earliest to occur of the following:
1. The date You cease to be Disabled;
2. The 91st day following the date We mail to You a request for additional Proof of Disability with which You fail to comply;
3. The date You refuse to submit to a medical examination or to cooperate with Our chosen health care provider;
4. The date You refuse to submit to or undergo vocational rehabilitation (which determines employment opportunities, if any, for individuals with disabilities);
5. The date at which You’ve resided outside of the United States of America, or one of its territories during any 6 consecutive months for which premium had been waived;
6. The effective date of an individual life insurance policy issued to You under the “Life Insurance Conversion Benefit” section.

F. Premiums
1. Premium payment must continue until the later of the end of Your Elimination Period or the date Your claim for the Waiver of Premium Benefit is approved by Us.
2. If Your Waiver of Premium benefit terminates because You cease to be Disabled or You fail to submit to a medical exam or cooperate with the examiner, for coverage to continue, You must be an Eligible Employee and premiums must resume on the next premium due date, or You must continue coverage as provided for under the “Life Insurance Conversion Benefit” section.

G. Amount of Insurance
1. The amount of Life Insurance continued under the Waiver of Premium Benefit is the amount in effect on the day before You became Disabled, if you were Actively at Work.
2. Insurance will be reduced or terminated according to the Group Policy provisions in effect on the day before You became Disabled.
3. Your Life Insurance amount will not increase while Your Life Insurance premiums are being waived.

H. We will not waive premiums if Your Disability results from intentionally self-inflicted Injuries or Physical Diseases, while sane or insane, or from Your voluntary participation in an illegal activity.

I. If You die during the Elimination Period and are otherwise eligible for the Waiver of Premium Benefit, the Elimination Period will not apply.

J. We may require further Proof of Disability in intervals that are reasonable based on Your type of Disability.

K. Investigation Of Claim
With respect to benefits that are claimed during an Insured Person’s lifetime, We may require him or her to undergo examination at reasonable intervals, at Our expense. Any such examinations will be conducted by appropriate Physician of Our choice. We may deny or suspend benefits if You fail to attend an examination, or do not give full effort and cooperation to the examiner.

GTL-C900-0608
VI.  LIFE INSURANCE - LIVING BENEFIT

**Terminally Ill** and **Terminal Illness** mean a medical condition that is expected to result in Your death within 12 months.

A. If You become Terminally Ill while covered for life insurance under the Group Policy You may elect to receive the Living Benefit as provided for under this section.

B. The Living Benefit will be an amount equal to 50% of Your Employee Basic Life Insurance in effect on the date Your election is made, subject to a minimum of $5,000 and a maximum of $50,000. The amount payable will be equal to the Living Benefit less applicable amounts, if any, charged for an investment loss (interest) and administrative fees.

C. The payment will be made in one lump sum to You or to the payee You appropriately assign.

D. The Living Benefit will not be available if:
   1. You have any portion of any Life Insurance or ownership rights thereof absolutely or irrevocably assigned or transferred;
   2. You have made an irrevocable beneficiary designation;
   3. the insurance proceeds are subject to a court order under a divorce decree, separate maintenance agreement or property settlement agreement;
   4. You have filed for bankruptcy, unless You give Us written approval from the bankruptcy court for payment of the Living Benefit;

E. No payment will be made under this election unless and until We receive and approve of all of the following:
   1. Your signed and notarized election of this option on a form furnished by Us;
   2. signed and witnessed written statements of all irrevocable beneficiaries and assignees (and Spouse in marital property states) consenting to Your election of this option; and
   3. satisfactory written proof from a Physician other than Yourself or a member of Your or Your Spouse's immediate family that You have been diagnosed as being Terminally Ill and that You are of sound mind and under no constraint or undue influence.

F. We may require a second opinion and examination of Your condition at Our own expense by a Physician of Our choice.

G. Payment of the Living Benefit will reduce correspondingly the face amount of Your life insurance benefits under the Group Policy. This will result in reduced life insurance proceeds payable to Your beneficiary at Your death. Furthermore, any amount of insurance that would otherwise be continued will be reduced proportionately, as will the maximum face amount available under the “Life Insurance Conversion Benefit” section.

H. Premium payments must continue to be paid for Your life insurance unless You qualify to have Your life insurance premium waived. The premium due will be based on the amount of insurance remaining in force after deducting the amount of the Living Benefit.

I. Payment of the Living Benefit will not affect the amount of, or change an existing beneficiary designation for, the AD&D Benefit, if any, in effect and kept in force under the Group Policy.

J. Your election together with Our payment of the Living Benefit constitute a valid and effective beneficiary designation change, but only with respect to the specified life insurance benefits, and only to the extent affected by the Living Benefit payment, and applicable interest and fees, if any, charged thereon.

K. Payment of the Living Benefit will be exempt from the claims of creditors and from legal process to the extent permitted by law.
L. All other provisions of the Group Policy, including the effective date provisions of any benefit increases and the provisions on benefit reductions because of amendments to the plan or benefit classification changes or Your attained age, remain valid and in effect. Any such life insurance benefit reduction will be calculated based on Your life insurance amount in effect immediately before the Living Benefit payment.

M. You are responsible for any tax consequences related to this benefit.

VII. LIFE INSURANCE CONVERSION BENEFIT

A. When Coverage Ends.
   1. If an Insured Person’s coverage under the Policy ends, the Insured Person may, as described below, apply for Our individual life insurance policy without submitting Evidence of Insurability.
      a. The Insured Person must complete an application, pay the first premium, and send them to Us within the 31-day period immediately following the date coverage ends under the Policy (the Conversion Period).
      b. The individual policy will become effective on the first day following the date coverage under the Policy ends.
      c. The Insured Person may convert all or part of the amount of life insurance benefit, as shown in the “Schedule of Benefits”.
   2. If an Insured Person has been insured under the Policy for at least five years and is no longer eligible due to cancellation of the Policy or cancellation of the class of insureds in which the Employee belonged, an Insured Person may convert the lesser of: (1) $10,000 or (2) all or part of the amount for which the Insured Person is no longer eligible for under the Policy.

B. Premiums.
   1. Premiums for such individual life policy will be based on: (1) Our usual rate for the amount and type of individual policy; (2) the Insured Person’s class of risk; and (3) the Insured Person’s attained age.
   2. If an Insured Person dies during the Conversion Period, the maximum amount of life insurance to which he or she would have been entitled to under such individual policy shall be payable as a claim under the Group Policy, whether or not application for the individual policy or the payment of the first premium has been made.
   3. The rights or benefits granted under this provision are in lieu of any other rights or benefits granted under the Group Policy.

VIII. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

A. If an Insured Person has an Accident while insured for Accidental Death and Dismemberment (AD&D) Insurance and the Accident results in a Loss (as defined below), We will pay benefits according to the terms of the Group Policy after We receive Proof of Loss.

B. Eligibility. An Insured Person must be a member of a class that is eligible for AD&D coverage under the Group Policy as specified in the “Schedule of Benefits”.

C. Definitions for AD&D Insurance
   1. Loss means Loss of one or more of the body parts or bodily functions listed under “AD&D Benefit” below, or as otherwise provided for under this “Accidental Death and Dismemberment Insurance” section, which:
      a. is caused solely and directly by an Accident;
      b. occurs independently of all other causes;
      c. occurs within 90 days after the Accident; and
      d. while the Insured Person is covered under the Group Policy.
2. **Accident:** A sudden, unexpected and unforeseen, identifiable event causing bodily injury, directly produced by specific accidental contact with another body or object. The Accident must occur while You are covered under the Group Policy.

3. With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint.

4. With respect to sight, speech or hearing, Loss means entire and irrecoverable Loss of that function.

**D. AD&D Benefit.** The AD&D Benefit is equal to a percentage of the AD&D Insurance Amount in effect on the date of the Accident, subject to the AD&D Reduction Schedule provision set forth in the “Schedule of Benefits”. The AD&D Insurance Amount is shown in the “Schedule of Benefits”. The percentage is shown below.

<table>
<thead>
<tr>
<th>Covered Losses</th>
<th>Maximum Amount Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life ........................................ .......................... 100%</td>
<td></td>
</tr>
<tr>
<td>Loss of both Hands or both Feet ........................ 100%</td>
<td></td>
</tr>
<tr>
<td>Loss of one Hand or one Foot .............................. 50%</td>
<td></td>
</tr>
<tr>
<td>Loss of one Hand and one Foot ............................ 100%</td>
<td></td>
</tr>
<tr>
<td>Loss of Entire Sight of both Eyes .......................... 100%</td>
<td></td>
</tr>
<tr>
<td>Loss of Entire Sight in one Eye ............................ 50%</td>
<td></td>
</tr>
<tr>
<td>Loss of one Hand or one Foot and Entire Sight of one Eye .......... 100%</td>
<td></td>
</tr>
<tr>
<td>Loss of Thumb and Index Finger of the same Hand .......... 25%</td>
<td></td>
</tr>
<tr>
<td>Loss of Speech OR Hearing in Both Ears ................. 50%</td>
<td></td>
</tr>
</tbody>
</table>

E. Unless otherwise specified, no more than 100% of the applicable AD&D Insurance Amount will be paid for all Losses resulting from one Accident. If an age reduction applies, the benefit reduces on the date You attain that age.

**F. AD&D Insurance Exclusions.** No AD&D Benefit is payable if the Loss is caused or contributed to by any of the following:

1. War or Act of War while you are in the military service. War means a state or period of declared or undeclared war whether civil or international, or any substantial armed conflict with organized forces of a military nature between nations, states or parties;
2. Suicide, attempted suicide or other intentionally self-inflicted Injury, while sane or insane;
3. Committing or attempting to commit a felony or assault, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing Your official duties;
4. Any Injury sustained while under the voluntary use or consumption of any poison, illegal drugs, or controlled substance, unless used or consumed according to the directions of a Physician;
5. Physical Disease existing at the time of the Accident;
6. Medical negligence and malpractice;
7. Bacterial infections (except due to accidental food poisoning or caused by an accidental wound);
8. Any Loss incurred for which any government body or its agencies are liable while the insured is on active duty or training in the Armed Forces, National Guard or Reserves, of any state or country;
9. Any Loss incurred while operating, riding in or descending from any aircraft, except as a fare-paying passenger on a commercial aircraft;

**IX. CLAIMS PROVISIONS**

**A. Filing A Claim**

1. To file a claim for benefits under this Certificate, the claimant (depending on the benefit the claimant could be an Insured Person, a beneficiary or personal representative of an Insured Person) must provide Us with
Proof of Loss in a timely manner. Or, upon receipt of written notice of claim, We will send the claimant a Claim Form for filing Proof of Loss. If the claimant does not receive such forms within 15 days after the giving of such notice, the claimant can send us, without the Claim Form, the written proof covering the occurrence.

2. Proof of Loss.
   a. Proof of Loss must be provided in writing to Us, at the claimant’s expense, within 90 days after the date of the loss if reasonably possible. If that is not reasonably possible, Proof of Loss must be provided no later than one year after expiration of that 90-day period, or the claim will be denied. The time limits under this section shall not apply while the claimant lacks legal capacity.
   b. **Proof of Loss** means satisfactory written proof that a loss occurred for which the Group Policy provides benefits, which is not subject to any exclusion, and which meets all other conditions for benefits. Proof of Loss includes any other information We may reasonably require in support of a claim for benefits under the Group Policy.

B. Notice of Decision on Claim
   1. We will evaluate a claim for benefits promptly after We receive it. Within 30 days after We receive the claim We will send the claimant:
      a. a written decision on the claim; or
      b. a notice that We are extending the period to decide the claim for an additional 45 days.
   2. If the claim is approved, We will pay benefits within 30 days after the Proof of Loss requirement is satisfied.
   3. If We extend the period to decide the claim, We will notify the claimant of the following:
      a. the reasons for the extension;
      b. when We expect to decide the claim; and
      c. any additional information We require to decide the claim.
   4. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may decide the claim based on the information We have received.
   5. If We deny any part of the claim, We will send the claimant a written notice of denial containing:
      a. the reasons for Our decision;
      b. reference to the parts of the Group Policy on which Our decision is based;
      c. a description of any additional information required to support the claim;
      d. information concerning the claimant's right to a review of Our decision.

C. Payment of Claims.
   Upon receipt of proper Proof of Loss, benefits will be paid within 30 days. If any claims payment interest accrues, interest will be paid in the amount determined by the State in which the claims are incurred.

Death Claims: If an Insured Person dies while insured for life insurance under the Group Policy, We will pay benefits according to the “Schedule of Benefits”, after We receive Proof of Loss, as follows.

1. The death benefit will be paid in a single sum or by any other method agreeable to Us and the beneficiary. Payment of the benefit will extinguish Our liability under the Group Policy for which the death benefit has been paid.
2. No Surviving Beneficiary. If You do not name a beneficiary, or if You are not survived by any named beneficiary, benefits will be paid to Your estate.
3. Dependent Benefits. Dependent Life Insurance benefits that are payable, but unpaid at the Insured Person’s death, will be paid in equal shares to the first surviving class of the following, if the Eligible Employee is dead:
   a. The children of the Dependent.
   b. The parents of the Dependent.
   c. The Insured Person’s estate.

   The following Dependent benefits, payable under the Group Policy, will be paid to the Eligible Employee if he or she is living:
   a. AD&D Insurance benefits;
b. Life Insurance benefits;
c. Supplemental Life Insurance benefits payable because of the death of Your insured Spouse or Child;
d. Living Benefit.

4. Facility of Payment. If the benefits provided by the Group Policy are payable to the Insured Person’s estate or to a beneficiary who is a minor or otherwise not legally competent to give a valid release, We may pay up to $500 to any person related to the Insured Person by blood or marriage. Any payment made in good faith will fully release Us to the limit of the payment. If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will pay the life proceeds to the legally appointed guardian. The guardian must provide Us with adequate written proof of such appointment. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law. Payment made before We have received written notice at Our home office of a valid claim by some other person releases Us from further obligation.

D. Review Procedure.
1. If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial.
2. The claimant may send Us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.
3. We will review the claim promptly after We receive the request. Within 60 days after We receive the request for review We will send the claimant:
   a. a written decision on review; or
   b. a notice that We are extending the review period for 60 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.
4. If We extend the review period, We will notify the claimant of the following:
   a. the reasons for the extension;
   b. when We expect to decide the claim on review; and
   c. any additional information We require to decide the claim.
5. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may conclude Our review of the claim based on the information We have received.
6. If We deny any part of the claim on review, the claimant will receive a written notice of denial containing:
   a. the reasons for Our decision.
   b. references to the provisions of the Group Policy on which Our decision is based.
   c. information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
7. The Group Policy does not provide voluntary alternative dispute resolution options.

X. GENERAL PROVISIONS

A. Naming a Beneficiary.
1. At the time You became insured under the Group Policy, You should have named a beneficiary of the proceeds of Your life insurance on the enrollment form.

2. You may have named primary beneficiaries and secondary beneficiaries. A secondary beneficiary will become a primary beneficiary if the named primary beneficiary is not living at the time of Your death. Two or more surviving primary beneficiaries will share equally, unless You specify otherwise.

3. AD&D Insurance death benefits will be distributed according to the beneficiary designation of Your corresponding life insurance.
4. You may change Your beneficiary designation at any time, subject to the following:
   a) The designation must be made in writing on a form suitable to Us;
   b) The designation must be dated and signed by You (and by your Spouse where required by law);
   c) The designation must relate and refer to the insurance provided under the Group Policy;
   d) If applicable, We must have the written consent of all irrevocable beneficiaries;
   e) You must not have assigned the ownership of Your insurance.

5. When a valid change of beneficiary is received by Us, the change will relate back to and take effect as of
   the date it was signed. This is the case whether You are alive or not when We receive the request. Even
   though the change of beneficiary will relate back to the date it was signed, it will be without prejudice to
   Us on account of any payment We have already made.

6. If We approve it, a written designation signed and dated by You under the Prior Plan will be accepted as
   Your beneficiary designation under the Group Policy.

B. Simultaneous Death Provision.
   If a beneficiary dies on the same day You die, or within 120 hours from Your time of death, benefits will be
   paid as if that beneficiary had died before You, unless Proof of Loss with respect to Your death is delivered to
   Us before the date of the beneficiary’s death.

C. Entire Contract, Changes
   1. This Certificate, including the Enrollment Form, Group Policy and any Riders, Amendment or attached
      papers, if any, constitutes the entire contract of Insurance. No change in this Certificate shall be valid until
      approved by an executive officer of Our company and unless such approval is endorsed hereon or attached
      hereto. No agent has authority to change this Certificate or waive any of its provisions.
   2. Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer,
      We have authority to control, manage, and interpret the Group Policy, to administer claims and to resolve
      all questions arising in the administration, interpretation and application of the Group Policy.
   3. Our authority includes, but is not limited to the following:
      a) the right to resolve all matters when a review has been requested;
      b) the right to establish and enforce rules and procedures for the administration of the Group Policy and
         any claim under it;
      c) the right to determine eligibility for insurance, entitlement to benefits, the amount of benefits payable
         and the sufficiency and the amount of information We may reasonably require to make determinations.

D. Incontestability of Insurance
   1. Any statement made to obtain or to increase insurance is a representation and not a warranty.
   2. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of
      insurance unless:
      a) the insurance would not have been approved if We had known the truth; and
      b) We have given You or any other person claiming benefits a copy of the signed written instrument which
         contains the misrepresentation.
   3. After insurance has been in effect for 2 years, during the lifetime of the Insured Person, We will not use a
      misrepresentation as a basis for reducing or denying a claim, unless it was a fraudulent misrepresentation.

E. Incontestability of the Group Policy or Employer Coverage under the Group Policy
   1. No misrepresentation by the Policyholder or Your Employer will be used as a basis for denying a claim, or
      for denying the validity of the Group Policy or Your Employer’s coverage under the Group Policy unless:
      a) the Group Policy would not have been issued or Your Employer’s coverage under the Group Policy
         would not have been approved if We had known the truth; and
b) We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

2. The validity of Your Employer’s coverage under the Group Policy will not be contested after it has been in force for 2 years, except for nonpayment of premium or fraudulent misrepresentations.

F. Clerical Error
1. Clerical error by Us, the Policyholder, Your Employer, or their respective Eligible Employees or representatives will not:
   a) cause a person to become insured under the Group Policy or a provision of it.
   b) invalidate insurance otherwise validly in force.
   c) continue insurance otherwise validly terminated.
   d) cause an Employer to obtain coverage under the Group Policy or a provision of it.

2. In the event that a clerical error results in an incorrect rate, We reserve the right to adjust the rate accordingly.

3. The payment of premium, by itself, will not obligate Us to provide benefits to anyone who is not eligible for coverage under the Group Policy.

4. Your Employer acts on its own behalf as Your agent, and not as Our agent. Your Employer has no authority to alter, expand or extend Our liability or to waive, modify or compromise any defense or right We may have under the Group Policy.

G. Misstatement
1. Age or Gender
   If the age or gender, or both, of a person has been misstated, We will make an equitable adjustment of premiums, benefits or both. The adjustment will be based on:
   a) the amount of insurance based on the correct age and gender; and
   b) the difference between the premiums paid and the premiums which would have been paid if the age and gender had been correctly stated.

2. A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

H. Assignment
   An Insured may not assign any of his or her rights, privileges or benefits under the Group Policy, unless approved by Us.

I. Conformity With State Laws
   If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.