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Placing People First

2018 Benefits Guide

January 1—December 31

Michigan Employees

Welcome to Your Benefit Options

2018 Benefit Guide

Whether you are a current team member reviewing your benefit options for the 2018 Open Enrollment or a new team member at Epitec, we hope you will find this 2018 Benefits Guide helpful.

Epitec has partnered with some of the best names in the industry for your benefits package. This guide reviews the features of our benefits programs offered to you. Each year, you have the opportunity to review your choices and make new decisions.

In preparation for this time, the company conducts an extensive review of the current benefits package. We evaluate insurance expenses and trends, ensure compliance with all healthcare regulations, and look to find alternative ways to control costs while continuing to offer a high level of coverage to our employees and their families.

Effective January 1, 2018, the following changes will be made:

- ***BCBSM PPO:***
  - Prescription Drug - Formulary change to Custom Select
- **24/7 Online Health—New App BCBSM Online Visits (www.bcbsmonlinevisits.com)**
- ***Adding Voluntary Accident Plan through Guardian***
  - Accident Insurance helps offset the unexpected medical expenses that may result from an accidental injury (on or off the job). Accident insurance policies provide you with benefits for a wide range of situations from a fracture to surgery. For more information, please refer to page 14

****NOTE: ALL EMPLOYEES WILL AUTOMATICALLY BE ENROLLED IN THE ACCIDENT PLAN. YOU MUST WAIVE THE BENEFIT IN ADP IF YOU DO NOT WANT IT****

- ***There will be no changes to the BCN HMO/Dental/Vision/STD/LTD/Voluntary Life.***

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Eligibility

You are eligible for benefits if you are a full-time employee, unless otherwise stated. Full-Time employees must be regularly scheduled to work 30 hours or more per week.

As a participant in the Eptiec employee benefits program, you may choose coverage for:

- Yourself only
- Yourself and one dependent
- Yourself and two or more dependents

Eligible dependents are defined as your:

- Legal spouse
- Dependent Children
    - Natural child(ren)
    - Legally adopted child(ren)
    - Child(ren) placed in your home for legal adoption
    - Stepchild(ren)
    - Child(ren) over whom you have legal guardianship

If I am a new hire, when am I eligible for benefits?

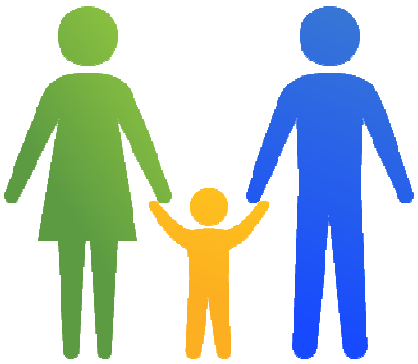
If elected, coverage will go into effect on the 1st of the month following 60 days of employment.

How long can my dependent children remain on my coverage?

Medical/Dental/Vision - Children are considered eligible dependents until the end of the calendar year in which they turn 26.

Coverage can also continue past the age limit above if your child is incapable of self-support because of mental or physical disability. Proof of mental or physical disability is required and must be approved by the plan.

Employees may not be covered as both an employee and a dependent under Epitec's employee benefits, nor can any person be covered as a dependent of more than one employee.



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to page 17 for further details.

Open Enrollment

2018 Benefit Guide

Open enrollment is the time of year when you can make any necessary changes to your current health election. Epitec's open enrollment takes place during the month of **November for an effective date of January 1st**. The elections that you choose may be changed only at the next Open Enrollment Period, unless you have a Qualified Change of Status which would allow for a Special Open Enrollment.

In accordance with federal regulations, the benefits you choose in your benefit package will remain in effect through the next plan year. However, you may be allowed to make changes in certain benefits if you have a **Qualified Change of Status Event.** Examples of qualified change of status events are listed below:

- Employee Change in Status
  - Change in employee's legal marital status
  - Change in number of dependents
  - Change in employment status (including change in work site location)
  - **Change in residence (HMO Only)**
  - Dependent satisfies (or ceases to satisfy) eligibility requirements
  - Commencement or termination of adoption proceedings
- Significant Cost Increase
- Significant Curtailment of Coverage
- Addition or Elimination of Benefit Package Option
- Change in Coverage of Spouse or Dependent Under Other Employer's Plan
- FMLA Leave*
- COBRA Event
- Judgment, Decree, or Court Order
- Medicare or Medicaid Entitlement
- Employee/dependent loss of Medicaid or Children's Health Insurance Program (CHIP) or employee/dependent entitlement for a premium assistance program through Medicaid or CHIP. **Please note that these qualifying events have a special 60 day enrollment period rather than the typical 30 day enrollment period.**

Note that there are certain limitations and/or exclusions within <u>each</u> qualifying event. For more information please see your Human Resource Department.

The Internal Revenue Service requires that the change in benefits must be consistent with the change of status. If you have a change, you must complete a new Enrollment Form within 30 days of the event. These forms are available from your Human Resource Department . **Changes made after 30 days will not be accepted.**

Notice of HIPAA Special Open Enrollment Rights – If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. In addition, if you acquire a new dependent, as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your newly acquired dependents provided that you request enrollment within 30 days after the marriage, birth, adoption and placement for adoption.

Blue Cross Blue Shield Simply Blue PPO Option

2018 Benefit Guide

Blue Cross Blue Shield Blue Care Network of Michigan	IN-NETWORK	OUT-OF-NETWORK
Deductibles Per Calendar year (January-December)	$4000 for one member, or $8000 for family (two or more members)	$4000 for one member, or $8000 for family (two or more members)
Coinsurance for General Services	Plan Pays 70% / Member Pays 30%	Plan Pays 50% / Member Pays 50%
Out-of-Pocket Maximum *(Includes Deductible, Coinsurance & Copays)*	$6,350 for one member, or $12,700 for family (two or more members)	$12,700 for one member, or $25,400 for family (two or more members)
	PREVENTIVE CARE SERVICES	
Health Maintenance Exam *(Covered services are based on recommendations from the U.S. Preventive Services Task Force)*	Covered 100%, one per calendar year	Not covered
	PHYSICIAN, EMERGENCY, URGENT CARE SERVICES	
	Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex) therapeutic and surgery. An office visit copay still applies to the exam	
Office Visits	$40 Copay	Covered 50% after Deductible
Chiropractic	$40 Copay	Covered 50% after Deductible
	Limited to a combined 12-visit maximum per member per calendar year.	
Outpatient Physical, Speech and Occupational Therapy	Covered 70% after Deductible	Covered 50% after Deductible
	Limited to a combined 30-visit maximum per member per calendar year	
Urgent Care Facility	$60 Copay	Covered 50% after Deductible
Emergency Room	$250 Copay Copay waived if admitted	
	OTHER COVERED SERVICES	
Diagnostic Services	Covered 70% after Deductible	Covered 50% after Deductible
In-Patient Hospital	Covered 70% after Deductible	Covered 50% after Deductible
	PRESCRIPTION DRUGS - CUSTOM SELECT FORMULARY	
Generic Drugs	$20 Copay	$20 Copay plus an additional 25% of BCBSM approved amount of drug
Formulary	$60 Copay	$60 Copay plus an additional 25% of BCBSM approved amount of drug
Non-formulary	$80 or 50% Copay (max $100)	$80 or 50% Copay plus an additional 25% of BCBSM approved amount of drug
Mail Order (home delivery)	$40 Generic / $120 Formulary $160 or 50% ($200 max) Non-formulary	No coverage

To locate a BCBSM PPO participating doctor or hospital, please visit www.bcbsm.com.

This is only a partial benefit summary. To see additional benefits, please see the appendix.

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Blue Care Network HMO Option #2

Blue Cross Blue Shield Blue Care Network of Michigan	In-Network Benefits Only *PCP Focus Network*
Deductible *(Per Calendar Year)*	$2500 per Individual $5000 per Family
Coinsurance	20% after Deductible
Your Out of Pocket Maximum ***(includes deductible, coinsurance, and fixed dollar copays)***	$5000 per Individual $10,000 per Family
Office Visits	$40 Copay
Preventive Care	Covered 100%
Specialist Visits (when referred)	$50 Copay after Deductible
Chiropractic (when referred)	$50 Copay after Deductible Maximum of 30 visits per calendar year
Outpatient Physical, Speech & Occupational Therapy	$50 Copay One period of treatment for any combination of therapies within 60 consecutive
Urgent Care Facility	$60 Copay
Emergency Room	$150 Copay after Deductible
Diagnostic Services	Covered 80% after Deductible
In-Patient Hospital	Covered 80% after Deductible
	Prescription Drug Plans
Tier 1, 2 & 3 Drugs	50% Coinsurance ($5 minimum, $100 maximum)
Sexual Dysfunction Drugs	50% Coinsurance
Woman's Contraceptives	Tier 1 - 100%
Mail Order Prescription Drugs	2X the applicable copay uo tp a 90 day supply

To locate a BCN HMO participating PCP Focus doctor or hospital, please visit www.bcbsm.com.

- Click on Find a Doctor
- Under "Choose a Health Plan", choose "Employer Group Plans"
- Under HMO Plans, click on "Blue Care Network PCP Focus Network (HMO)"
- Enter the City/Zip, and click "Search"

This is only a partial benefit summary. To see additional benefits, please see the appendix.

Blue Cross
Online Visits™

Medical

Getting health care online in 2018: What you need to know

When you use **Blue Cross Online Visits℠** (previously called 24/7 online health care), you'll have access to online medical services anywhere in the U.S.

You can rest assured knowing you and your covered family members can see and talk to a doctor for minor illnesses such as a cold, flu or sore throat when your primary care doctor isn't available.

After Jan. 1, 2018, here's what you need to do to use online visits:

- **Mobile** – Download the BCBSM Online Visits℠ app
- **Web** – Visit **bcbsmonlinevisits.com**
- **Phone** – Call **1-844-606-1608**

If you're new to online visits, sign up after Jan. 1, 2018. Be sure to add your Blue Cross or Blue Care Network health plan information. You'll also need to add the service key **BLUE**.

If you currently use Blue Cross' 24/7 online health care from Amwell®, use the new app, website or phone number after Jan. 1, 2018. Your login information stays the same and will be transferred to our new site. Verify your password and your account information. You may need to re-enter some information.

Online medical care doesn't replace primary doctor relationships.

The website and app use the American Well® technology platform and provider network. American Well® is an independent company that provides online visits for Blue Cross and BCN members.

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

Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

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	BCBSM EPO	
	In-Network	Out-of-Network
Deductible	$25 per Individual Max $75 per Family	N/A
Annual Maximum	$1,000 per Member	
Class I—Preventative	Covered 100%	Not Covered
Class II—Basic	Covered 80%	Not Covered
Class III—Major	Covered 50%	Not Covered
	12 Month Waiting Period on Major Services	
Class IV—Ortho	Not Covered	

Network access information

With Blue Dental EPO, members **must** choose a dentist who is a member of the Blue Dental PPO network. Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance amounts. Members also receive discounts on non covered services when they use PPO dentists (in states where permitted by law).

To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

Note: If you go to a non-PPO (out-of-network) dentist, you are responsible for all costs for services rendered.

	BCBSM PPO (*High Plan*)	
	In-Network	**Out-of-Network**
Deductible	$25 per Individual Max $75 per Family	$25 per Individual Max $75 per Family
Annual Maximum	$1,000 per Member	
Class I—Preventative	Covered 100%	Covered 100%
Class II—Basic	Covered 80%	Covered 80%
Class III—Major	Covered 50%	Covered 50%
	12 Month Waiting Period on Major Services	
Class IV—Ortho	Not Covered	

Network access information

With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on non covered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

Blue Par Select℠ arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com**.

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

	VSP Vision - VSP Choice	
	In-Network	**Out-of-Network** **You pay (after copay if applicable)**
Exam Copay	$10	Reimbursement up to $34
Materials Copay	$10 (Frames Allowance - you will pay 80% of amount over $100)	Single Vision Lenses/ Lined Bifocal Lenses/Lined Trifocal Lenses— Reimbursement up to approved amount less $10 copay Frames - Reimbursement up to $38.25
Elective Contact Lenses	Covered in lieu of lenses and frames ($100 Allowed amount) Once every 12 months	Reimbursement up to $100
Service Frequencies **Exam** **Lenses** **Frames**	Once Every 12 Months	

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Life Insurance Plans

Epitec Inc., provides all eligible employees **Basic Life and Accidental Death & Dismemberment** Insurance through Guardian. Life insurance provides a benefit to your beneficiary in the event of your death while you are employed. The AD&D amount is equal to your life insurance amount and is also payable to your beneficiary if you die as a result of an accident. The AD&D insurance may also pay a benefit to you if you have certain injuries. Please review your Guardian plan booklet for more details.

	Basic Life and AD&D
Life Coverage Amount	$15,000
Accidental Death & Dismemberment	$15,000
Benefit Reduction Schedule	Reduces by 35% at age 65, 60% at age 70, 75% at age 75 and 85% at age 80

All eligible employees have the opportunity to participate in a **Voluntary Supplemental Life Insurance** plan through Guardian. You may elect to purchase Voluntary Supplemental Life Insurance for yourself, spouse and dependent child(ren). ***There is NO Open Enrollment for the Voluntary Life coverage. If you did not participate when first eligible, benefits may be limited and/or denied if you wish to enroll in the future.*** Below is a summary of the plan. Please review your Guardian plan booklet for more details.

	Voluntary Life and AD&D
Employee Life Insurance	Available in increments of $10,000 to a maximum of $500,000 (Guaranteed Issue: $100,000 if under Age 65)
Spousal Life Insurance	May be purchased up to 50% of employee amount Maximum election of $250,000 (Guaranteed Issue: $10,000 if under Age 65)
Dependent Children Life Insurance	May be purchased up to 10% of employee amount Maximum election of $10,000 (Guaranteed Issue: $10,000) Age:14 days to 6 months - $500 Benefit Birth to 14 days - No Benefit
Benefit Reduction Schedule	Reduces by 35% at age 65, 60% at age 70, 75% at age 75 and 85% at age 80
Accidental Death & Dismemberment	Benefit will match your elected voluntary life amount
Added Feature	Will Prep Services

Do you remember who you listed as your beneficiary?

Take the time to update your information!

Disability Plans

Epitec provides all eligible employees the opportunity to participate in a **Voluntary Short Term Disability** Insurance through Guardian. Short term disability provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury. Short term disability provides an important source of income that can affect your financial security and that of your family. Please review your Guardian plan booklet for more details.

	Short Term Disability
Benefit Amount	60% of your Base Weekly Earnings
Benefit Weekly Maximum	$1,150
Benefit Duration	26 weeks
Benefits Begin On: ° **Due to an Accident** ° **Due to an Illness**	 15th day 15th day
Pre-Existing Limitation	3 months look back; 12 months after 2 week limitation

Epitec provides all eligible employees the opportunity to participate in a **Voluntary Long Term Disability** Insurance through Guardian**.** Long Term Disability Income provides an important source of income if you become disabled and unable to work for an extended period of time. Please review your Guardian plan booklet for more details.

	Long Term Disability
Benefit Amount	60% of your Base Monthly Earnings
Benefit Monthly Maximum	$5,000 per month
Elimination Period	181 days
Benefit Duration	For the first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education. You will receive benefit payments to age 65.
Pre-Existing Limitation	6 months look back; 24 months after exclusion

Accident Plan

Epitec provides all eligible employees the opportunity to participate in a **Voluntary Accident Insurance** plan through Guardian. This plan pays a lump sum benefit for covered injuries and specified accident related expenses such as hospitalization, physical therapy, emergency room treatment, fractures and dislocations, transportation, lodging and more. Below is a summary of the plan.

You will automatically be enrolled in this benefit. You MUST waive this plan in ADP if you do not wish to participate in this voluntary plan!

Accident	Benefit
Accident Coverage	On and Off Job
Wellness Benefit	Provides a $50 per year benefit for completing certain routine wellness screenings or procedures
Accident Emergency Treatment	$150
Ambulance	$100
Coma	$7500
Emergency Dental Work	$200 Crown / $50 Extraction
Eye Injury	$200
Fracture	Schedule of Benefits—up to $4500
Hospital Admission	$750
Hospital Confinement	$175 per day up to 1 year
Joint Replacement	Hip $1500 / Knee $750 / Shoulder $750
Lodging	$100 per day, up to 30 days for companion hotel stay
Occupational/Physical Therapy	$25 per day, up to 10 days
Surgery	Schedule of benefits, up to $1000
X-Ray	$20

Women's Health and Cancer Rights Act of 1998 (Janet's Law)

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible, and coinsurance provisions. They are also subject to medical insurance limitations and exclusions. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

Newborns' and Mothers' Health Protection Act

The Newborns' Act is a federal law that prohibits group health plans and insurance companies (including HMOs) that cover hospitalization in connection with childbirth from restricting a mother's or newborn's benefits for such hospital stays to less than 48 hours following a natural delivery or 96 hours following delivery by cesarean section, unless the attending doctor, nurse midwife or other licensed health care provider, in consultation with the mother, discharges the mother or newborn child earlier.

How to Obtain a Notice of HIPAA Privacy Practices

To obtain a notice of HIPAA privacy practices please contact your Human Resource Department or your insurance carrier at the telephone numbers listed at the end of this booklet.

Tell Us When You're Medicare Eligible

Please notify your Human Resource Department when you or your dependents become eligible for Medicare. We are required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the health plan pays primary. You must also contact Medicare directly to notify them that you have health care coverage through an employer group. Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian, to update or change Medicare records. The toll free number to contact Medicare Coordination of Benefits Contractor is 1-800-999-1118.

Summary of Benefits and Coverage

In addition, health plans are required to provide members with a Summary of Benefits and Coverage (SBC). The SBC is different from the standard summary, in that it provides members with improved standardized information designed to help better understand your coverage and compare the options available to you. The SBC is included in this guide.

Patient Protection

HMO Insurance plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan designates a primary care provider automatically, until you make this designation, the insurance carrier may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the insurance carrier. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HMO direct.

Children's Health Insurance Program (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires employers that maintain group health plans in certain states to notify their employees of potential opportunities for premium assistance available in their state. If you are an employees residing in one of the following states, please see the attached notice (please note these states are subject to change): AL, AK, AZ, AR, CO, FL, GA, ID, IN, IA, KS, KY, LA, ME, MA, MN, MO, MT, NE, NV, NH, NJ, NY, NC, ND, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI, and WY.

ACA Health Care Reform Law

Congress passed the ACA, a significant health care reform law, in March 2010. The ACA is a far-reaching law that affects all aspects of the health care system. Consumers, health care providers, insurance companies and employers are all impacted. Beginning in 2014, the ACA requires most individuals to obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. If you are covered under a health plan offered by your employer, or if you are currently covered by a government program such as Medicare, you can continue to be covered under those programs. There is a graduated tax penalty, or fee, for individuals who do not obtain health insurance by the time they file their taxes in 2014 and thereafter.

Nondiscrimination Statement: Discrimination is Against the Law

Del Bene Produce complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www**.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we- serve/seniors/health-care/health-care-programs/programs- and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance /healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebr aska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages /default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Important Notice from Epitec
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Epitec and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Epitec has determined that the prescription drug coverage offered by BCBSM/BCN is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Credible Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **Epitec** coverage may be affected.

If you do decide to join a Medicare drug plan and drop your **Epitec** coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with **Epitec** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without credible coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. **NOTE:** You'll get this notice each year (before the next period you can join a Medicare drug plan), and if this coverage through **Epitec** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2018
Name of Entity/Sender:	Epitec, Inc
Contact--Position/Office:	Human Resource Department
Address:	24800 Denso Drive, Suite 150
Phone Number:	(248) 353.6800

Appendix

Epitec Inc.
Simply Blue^{SM} PPO Plan $4000/30% LG
Effective Date: On or after January, 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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note:A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select **Approving covered services**.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles	$4,000 for one member, $8,000 for the family (when two or more members are covered under your contract) each calendar year	$4,000 for one member, $8,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $40 copay for office visits and office consultations with a non-specialist provider • $40 copay for medical online visits • $60 copay for office visits and office consultations with a specialist provider • $40 copay for chiropractic and osteopathic manipulative therapy • $250 copay for emergency room visits • $60 copay for each urgent care visit	$250 copay for emergency room visits
Coinsurance amounts (percent copays) **Note**: Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 30% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 50% of approved amount for most other covered services
Annual coinsurance maximums	None	None
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam -includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered

Benefits	In-network	Out-of-network
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not Covered
Pap smear screening -laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Prescription contraceptive devices- includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note**: Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance	50% after out-of-network deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy-routine or medically necessary	100% (no deductible or copay/coinsurance), for the first billed colonoscopy **Note**: Subsequent colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance	50% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits-must be medically necessary	• $40 copay per office visit with a non-specialist provider • $60 copay per office visit with a specialist provider **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	50% after out-of-network deductible
Outpatient and home medical care visits-must be medically necessary	70% after in-network deductible	50% after out-of-network deductible
Office consultations-must be medically necessary	• $40 copay for each office consultation with a non-specialist provider • $60 copay for each office consultation with a specialist provider **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office consultation copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office consultation.	50% after out-of-network deductible
Online visits – must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered.	$40 copay for online visits	50% after out-of-network deductible

Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits	$60 copay for each urgent care visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	50% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$250 copay per visit (copay waived if admitted)	$250 copay per visit (copay waived if admitted)
Ambulance services-must be medically necessary	70% after in-network deductible	70% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	70% after in-network deductible	50% after out-of-network deductible
Diagnostic tests and x-rays	70% after in-network deductible	50% after out-of-network deductible
Therapeutic radiology	70% after in-network deductible	50% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Postnatal care	70% after in-network deductible	50% after out-of-network deductible
Delivery and nursery care	70% after in-network deductible	50% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a **participating** hospital.	70% after in-network deductible Unlimited days	50% after out-of-network deductible
Inpatient consultations	70% after in-network deductible	50% after out-of-network deductible
Chemotherapy	70% after in-network deductible	50% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care-must be in a **participating** skilled nursing facility	70% after in-network deductible Limited to a maximum of 120 days per member per calendar year	70% after in-network deductible
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	70% after in-network deductible	70% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization- consult with your doctor	70% after in-network deductible	70% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery- includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	70% after in-network deductible	50% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see "**Preventive care services**."	70% after in-network deductible	50% after out-of-network deductible
Elective abortions	70% after in-network deductible	50% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants-must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants -must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	70% after in-network deductible	50% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	70% after in-network deductible	50% after out-of-network deductible
Kidney, cornea and skin transplants	70% after in-network deductible	50% after out-of-network deductible

Mental health care and substance use disorder treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	70% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	70% after in-network deductible	50% after out-of-network deductible
Outpatient mental health care: • Facility and clinic **Note:** Online visits by a non-BCBSM selected vendor are not covered.	70% after in-network deductible	70% after in-network deductible in participating facilities **only**
• Physician's office	70% after in-network deductible	50% after out-of-network deductible
Outpatient substance use disorder treatment- in approved facilities **only**	70% after in-network deductible	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	70% after in-network deductible	70% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	70% after in-network deductible	50% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	70% after in-network deductible	50% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note**: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note**: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 70% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	50% after out-of-network deductible
Allergy testing and therapy	70% after in-network deductible	50% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$40 copay per visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.	50% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy-provided for rehabilitation	70% after in-network deductible	50% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 30-visit maximum per member per calendar year	
Durable medical equipment **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	70% after in-network deductible	70% after in-network deductible
Prosthetic and orthotic appliances	70% after in-network deductible	70% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Blue Preferred® Rx LG Prescription Drug Coverage
Custom Select $20/$60/50%/20%/25%
Benefits-at-a-glance
Effective Date: On or after January, 2018

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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copays and coinsurance amounts, are subject to the same annual out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	You pay $20 copay	You pay $20 copay	You pay $20 copay	You pay $20 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $40 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $50 copay	No coverage	No coverage
	84 to 90-day period	You pay $50 copay	You pay $50 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $60 copay	You pay $60 copay	You pay $60 copay	You pay $60 copay plus an additional 25% of BCBSM approved amount for the drug

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 60-day period	No coverage	You pay $120 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $170 copay	No coverage	No coverage
	84 to 90-day period	You pay $170 copay	You pay $170 copay	No coverage	No coverage
Tier 3 - Non Preferred brand-name drugs	1 to 30-day period	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100 **plus** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $160 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
	84 to 90-day period	You pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	You pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
Tier 4 - Generic and preferred brand-name specialty drug	1 to 30-day period	You pay 20% of approved amount, but no more than $200	You pay 20% of approved amount, but no more than $200	You pay 20% of approved amount, but no more than $200	You pay 20% of approved amount, but no more than $200 **plus** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 - Nonpreferred brand-name specialty drugs	1 to 30-day period	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300 **plus** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/ coinsurance	100% of approved amount less plan copay/ coinsurance	100% of approved amount less plan copay/ coinsurance	75% of approved amount less plan copay/ coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs. • **Tier 4 (generic and preferred brand-name specialty)** - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay/coinsurance. • **Tier 5 (nonpreferred brand-name specialty)** - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay/coinsurance.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. 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**.
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Simply Blue[SM] PPO 4000

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2018
Coverage for: Individual/Family **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-Of-Network	
What is the overall deductible?	$4,000 Individual /$8,000 Family	$4,000 Individual /$8,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,350 Individual /$12,700 Family	$12,700 Individual /$25,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No		You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$60 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or prescribed over-the-counter drugs	$20 copay; deductible does not apply	$20 copay **plus** 25% of approved amount; deductible does not apply	30-day supply. 90-day retail and mail order copays are 3x standard retail copays-$10. 90-day supply not covered out-of-network.
	Preferred brand-name drugs	$60 copay; deductible does not apply	$60 copay **plus** 25% of approved amount; deductible does not apply	
	Non-Preferred brand-name drugs	$80 or 50% (whichever is greater) max $100; deductible does not apply	$80 or 50% (whichever is greater) max $100 **plus** 25% of approved amount; deductible does not apply	
	Generic and preferred brand-name Specialty drugs	20% coinsurance up to $200; deductible does not apply	20% coinsurance up to $200 **plus** 25% of approved amount; deductible does not apply	15 or 30-day supply per fill. Preauthorization is required.
	Nonpreferred brand-name Specialty drugs	25% coinsurance up to $300; deductible does not apply	25% coinsurance up to $300 **plus** 25% of approved amount; deductible does not apply	15 or 30-day supply per fill. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay; deductible does not apply	$250 copay; deductible does not apply	Copay waived if admitted
	Emergency medical transportation	30% coinsurance	30% coinsurance	Mileage limits apply
	Urgent care	$60 copay; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization may be required
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	30% coinsurance	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required
If you are pregnant	Office visits	No charge; deductible does not apply	50% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	30% coinsurance	30% coinsurance	Preauthorization is required
	Rehabilitation services	30% coinsurance	50% coinsurance	Physical, Speech, and Occupational Therapy is limited to a **combined** maximum of 30 visits per member per calendar year
	Habilitation services	30% coinsurance for Applied Behavioral Analysis; 30% coinsurance for Physical Speech and Occupational Therapy	30% coinsurance for Applied Behavioral Analysis; 50% coinsurance for Physical Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	30% coinsurance	30% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	30% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No charge; deductible does not apply	No charge; deductible does not apply	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Non-Emergency care when traveling outside the U.S.
- Coverage outside of the U.S., see http://provider.bcbs.com
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-752-1455. Othercoverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling 1-800-752-1455.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) coinsurance	30 %
Other coinsurance	30 %

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$40
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,000**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) coinsurance	30 %
Other coinsurance	30 %

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,900
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,460**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) coinsurance	30 %
Other coinsurance	30 %

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون اية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܒܡܗܝܪܢܘܬܘܢ، ܣܢܝܩܐ ܝܠܗ ܠܗܝܪܬܐ، ܐܢܬܘܢ ܐܝܬܠܘܟܘܢ ܙܕܩܐ ܕܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܡܓܢܐ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܡܚܘܢ ܩܠ ܠܡܢܝܢܐ ܕܚܬܡܬܐ ܕܡܫܡܫܢܘܬܐ ܕܥܡܝܠܐ ܥܠ ܣܛܪܐ ܕܟܪܬܘܢ ܝܢ 877-469-2583 TTY:711 ܐܢ ܠܐ ܗܘܝܬܘܢ ܗܕܡܐ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Deductible, Copays and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible	$2,500 per member/$5,000 per contract per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$40 for office visits
	$60 for urgent care visits
	$150 for emergency room visits
	No fixed dollar copay for ambulance services. See below for applicable coinsurance
	$50 for referral physician visits
Coinsurance	50% for select services as noted below
	20% for select services as noted below
Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$5,000 per individual/$10,000 per family

Preventive Services

Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services

PCP Office Visits	$40 Copay
Online Visits	$40 Copay
Consulting Specialist Care	$50 Copay after deductible

Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	$150 Copay after deductible
Urgent Care Center	$60 Copay
Ambulance Services	80% after deductible

Benefits Selected - CI20%,D2500,DSR20%,VACR50,ER150,CO40,5000PM,PD50%C,MOPD2O,50RP,UR60

Diagnostic Services

Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible
Radiation Therapy	80% after deductible

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$40 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	80% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	80% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% (When authorized) after deductible
Home Health Care	$50 Copay after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	80% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Benefits Selected - CI20%,D2500,DSR20%,VACR50,ER150,CO40,5000PM,PD50%C,MOPD2O,50RP,UR60

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	80% after deductible
Inpatient Substance Abuse Care	80% after deductible
Outpatient Mental Health Care	$40 Copay after deductible
Outpatient Substance Abuse	$40 Copay after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$40 Copay after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18	$50 Copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other Services

Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$50 Copay after deductible
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$50 Copay after deductible
	One period of treatment for any combination of therapies within 60 consecutive days per calendar year
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	80%
Prescription Drugs	Tier 1, 2 and 3 - 50% coinsurance (minimum $5, maximum $100); 30 day supply
	Sexual Dysfunction Drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
Hearing Aid	Not Covered

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between the Benefits-at-a-Gl and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. **Services must be provided or arranged by member's primary care physician or health plan.**

Benefits Selected - CI20%,D2500,DSR20%,VACR50,ER150,CO40,5000PM,PD50%C,MOPD2O,50RP,UR60

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call (800) 662-6667. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at (https://www.healthcare.gov/sbc-glossary) or call (800) 662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$2,500/$5,000	Generally, you must pay all of the costs from provider's up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Lab, preventive care, DME/P&O, diabetic supplies, PCP office visits, urgent care, allergy injections	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/)
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$5000/$10000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See (www.BCBSM.com) or call the phone number on the back of your ID card for a list of network providers. (800) 662-6667 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers: Member / Family	Why This Matters:
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit. Deductible does not apply	Not covered	Only the PCP office visit is exempt from the deductible. Other services received in the office, deductible applies. $40 copay for online visits.
	Specialist visit	$50 copay/visit	Not covered	Requires referral. $5 copay for allergy injections/50% coinsurance for allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge. Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance. Lab services covered full. Deductible does not apply to lab services	Not covered	May require preauthorization / No charge for lab services
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Requires preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at (www.bcbsm.com/customdruglist)	Tier 1 - Mostly Generics	50% coinsurance $5 min-$100 max/30 days. Deductible does not apply	Not covered	Preauthorization & step-therapy apply to select drugs. 50% coinsurance for sexual dysfunction drugs. Effective 1/1/2013 Tier 1 contraceptives are covered in full. 90 day mail order and retail copays are 2x the standard retail copays.
	Tier 2 - Preferred Brand	50% coinsurance $5 min-$100 max/30 days. Deductible does not apply	Not covered	
	Tier 3 - Non-Preferred Brand	50% coinsurance $5 min-$100 max/30 days. Deductible does not apply	Not covered	
	Specialty drugs	Tiered copays listed above apply. Deductible does not apply	Not covered	Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	May require preauthorization/50% coinsurance for weight reduction procedures,TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy,elective abortion
	Physician/surgeon fees	20% coinsurance	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergent transport is covered when preauthorized
	Urgent care	$60 copay/visit. Deductible does not apply	$60 copay/visit. Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Preauthorization is required. 50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy,elective abortion
	Physician/surgeon fee	No charge	Not covered	See "Outpatient surgery facility fee"

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$40 copay/visit	Not covered	Preauthorization is required
	Inpatient services	20% coinsurance	Not covered	Preauthorization is required
If you are pregnant	Office visits	No Charge. Deductible does not apply	Not covered	Postnatal and non-routine prenatal office visits-$40 copay. Only the routine prenatal visit is exempt from the deductible. Other services, deductible applies
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	$50 copay/visit	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	$50 copay/visit	Not covered	Requires preauthorization/ One period of treatment for any combination of therapies within 60 consecutive days per calendar year. Subject to meaningful improvement within 60 days.
	Habilitation services	ABA - $40 copay per visit. $50 copay per visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization.
	Skilled nursing care	20% coinsurance	Not covered	Requires preauthorization/Limited to 45 days per calendar year. Custodial care not covered.
	Durable medical equipment	50% coinsurance. Deductible does not apply	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered with 20% coinsurance. Deductible does not apply to diabetic supplies
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284,Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Plan Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available

To get help reading in your language call the customer service number on the back of your ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$100
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$1,300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,060**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ یان کەسێک کە یارمەتی دەدەیت پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە خۆڕایی یارمەتی و زانیاری بە زمانەکەی خۆت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەرانەوە بکە کە لەپشت کارتەکەتەوەیە، یان 877-469-2583 TTY: 711 ئەگەر ئێستا ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Blue Dental EPO 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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information

With Blue Dental EPO, members **must** choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

[1]*Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.*

[2] *A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.*

Note: If you go to a non-PPO (out-of-network) dentist, you are responsible for all costs for services rendered.

	PPO (In-network) Dentist	Non-PPO (Out-of-network) Dentist
Member's responsibility (deductible, coinsurance and dollar maximums)		
Deductible Applies to Class II and Class III services only	$25 per member limited to a maximum of $75 per family per calendar year	Not applicable
Coinsurance (percentage of BCBSM's approved amount for covered services)		
• Class I services	None (covered at 100% of approved amount)	Not covered
• Class II services	20% of approved amount	Not covered
• Class III services	50% of approved amount	Not covered
• Class IV services	Not covered	Not covered
Dollar maximums		
• Annual maximum for Class I, II and III services	$1,000 per member	Not applicable
• Lifetime maximum for Class IV services	Not covered	Not applicable
Class I services		
Oral exams	100% of approved amount, twice per calendar year	Not covered
A set (up to 4 films) of bitewing x-rays	100% of approved amount, twice per calendar year	Not covered
Dental prophylaxis (teeth cleaning)	100% of approved amount, twice per calendar year	Not covered
Pit and fissure sealants – for members age 19 and younger	100% of approved amount, once per tooth every 36 months when applied to the first and second permanent molars	Not covered
Palliative (emergency) treatment	100% of approved amount	Not covered
Fluoride treatments	100% of approved amount, two per calendar year	Not covered
Space maintainers – missing posterior (back) primary teeth – for members under age 19	100% of approved amount, once per quadrant per lifetime	Not covered

	PPO (In-network) Dentist	Non-PPO (Out-of-network) Dentist
Class II services		
Full-mouth and panoramic x-rays	80% of approved amount, once every 60 months	Not covered
Fillings – permanent (adult) teeth	80% of approved amount, replacement fillings covered after 24 months or more after initial filling	Not covered
Fillings – primary (baby) teeth	80% of approved amount, replacement fillings covered after 12 months or more after initial filling	Not covered
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount, three times per tooth per calendar year after six months from original restoration	Not covered
Oral surgery including extractions	80% of approved amount	Not covered
Root canal treatment – permanent tooth	80% of approved amount, once every 12 months for tooth with one or more canals	Not covered
Scaling and root planing	80% of approved amount, once every 24 months per quadrant	Not covered
Limited occlusal adjustments	80% of approved amount, **limited** occlusal adjustments covered up to five times in a 60-month period	Not covered
Occlusal biteguards	80% of approved amount, once every 12 months	Not covered
General anesthesia or IV sedation	80% of approved amount, when medically necessary and performed with oral surgery	Not covered
Repairs and adjustments of a partial or complete denture	80% of approved amount, six months or more after it is delivered	Not covered
Relining or rebasing of a partial or complete denture	80% of approved amount, once every 36 months per arch	Not covered
Tissue conditioning	80% of approved amount, once every 36 months per arch	Not covered
Class III services		
Onlays, crowns and veneer fillings – permanent teeth – for members age 12 and older	50% of approved amount, once every 60 months per tooth	
Removable dentures (complete and partial)	50% of approved amount, once every 60 months	Not covered
Bridges (fixed partial dentures) – for members age 16 and older	50% of approved amount, once every 60 months after original was delivered	Not covered
Endosteal implants – for members age 16 and older who are covered at the time of the actual implant placement	50% of approved amount, once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31	Not covered
Class IV services – Orthodontic services for dependents under age 19		
Minor treatment for tooth guidance appliances	Not covered	Not covered
Minor treatment to control harmful habits	Not covered	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered	Not covered
Post-treatment stabilization	Not covered	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins. **Services received outside the dental network are not covered.**

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Blue Dental PPO Plus 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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information

With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par Select℠ arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com**.

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, copays and dollar maximums)

Deductible Applies to Class II and Class III services only	$25 per member limited to a maximum of $75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services)	
• Class I services	None (covered at 100% of approved amount)
• Class II services	20% of approved amount
• Class III services	50% of approved amount
• Class IV services	Not covered
Dollar maximums	
• Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	Not applicable

Class I services

Oral exams	100% of approved amount, twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount, twice per calendar year
Full-mouth and panoramic x-rays	100% of approved amount, once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount, twice per calendar year
Pit and fissure sealants – for members age 19 and younger	100% of approved amount, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments	100% of approved amount, two per calendar year
Space maintainers – missing posterior (back) primary teeth – for members under age 19	100% of approved amount, once per quadrant per lifetime

Class II services

Fillings – permanent (adult) teeth	80% of approved amount, replacement fillings covered after 24 months or more after initial filling
Fillings – primary (baby) teeth	80% of approved amount, replacement fillings covered after 12 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount, three times per tooth per calendar year after six months from original restoration
Oral surgery including extractions	80% of approved amount
Root canal treatment – permanent tooth	80% of approved amount, once every 12 months for tooth with one or more canals
Scaling and root planing	80% of approved amount, once every 24 months per quadrant
Limited occlusal adjustments	80% of approved amount, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	80% of approved amount, once every 12 months
General anesthesia or IV sedation	80% of approved amount, when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	80% of approved amount, six months or more after it is delivered
Relining or rebasing of a partial or complete denture	80% of approved amount, once every 36 months per arch
Tissue conditioning	80% of approved amount, once every 36 months per arch

Class III services

Onlays, crowns and veneer fillings – permanent teeth – for members age 12 and older	50% of approved amount, once every 60 months per tooth
Removable dentures (complete and partial)	50% of approved amount, once every 60 months
Bridges (fixed partial dentures) – for members age 16 and older	50% of approved amount, once every 60 months after original was delivered
Endosteal implants – for members age 16 and older who are covered at the time of the actual implant placement	50% of approved amount, once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

Blue Vision℠ Voluntary with VSP Choice Network 12/12/12 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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Eye exam	None	None
Prescription glasses (lenses and/or frames)	A **combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount (no copay)	Reimbursement up to $34 (no copay) – (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses in any period of 12 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 12 **consecutive** months	

GUARDIAN®

EPITEC, INC.

Life Benefit Summary

Group Number: 00379860

About Your Benefits:

Your family depends on you in many ways and you've worked hard to ensure their financial security. But if something happened to you, will your family be protected? Will your loved ones be able to stay in their home, pay bills, and prepare for the future. Life insurance provides a financial benefit that your family can depend on. And getting it at work is easier, more convenient and more affordable than doing it on your own. If you have financial dependents- a spouse, children or aging parents, having life insurance is a responsible and a smart decision. Enroll today to secure their future!

What Your Benefits Cover:

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides $15,000 Basic Term Life coverage for all full time employees.	$10,000 increments to a maximum of $500,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage.	Not available
Spouse‡ Benefit	N/A	50% of employee coverage to a max of $250,000
Child Benefit	N/A	Your dependent children age birth† to 26 years. 10% of employee coverage to a max of $10,000. Coverage limits are based on child age.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $15,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 $100,000, 65-69 $10,000, 70+ $0. Spouse Less than age 65 $10,000, 65-69 $5,000, 70+ $0. Dependent children $10,000.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take your coverage with you if you terminate employment.	Yes, with age and other restrictions, including evidence of insurability	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes	Yes

	BASIC LIFE	VOLUNTARY TERM LIFE
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

† and Voluntary Life: Infant coverage is limited based on age.

‡ **Spouse coverage terminates at age 70.**

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00379860

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and view a video: https://www.guardianantytime.com/gafd/wps/portal/fdhome/employees/products-coverage/life

Weekly premiums displayed.

Policy Election Cost Per Age Bracket

		< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$10,000 Policy Election Amount										
Employee	$10,000	$.14	$.19	$.28	$.46	$.69	$1.09	$1.94	$3.53	$5.82
Spouse	$5,000	$.07	$.09	$.14	$.23	$.35	$.54	$.97	$1.77	$2.91
Child	$1,000	$.05	$.05	$.05	$.05	$.05	$.05	$.05	$.05	$.05
$20,000 Policy Election Amount										
Employee	$20,000	$.28	$.37	$.55	$.92	$1.39	$2.17	$3.88	$7.06	$11.63
Spouse	$10,000	$.14	$.19	$.28	$.46	$.69	$1.09	$1.94	$3.53	$5.82
Child	$2,000	$.09	$.09	$.09	$.09	$.09	$.09	$.09	$.09	$.09
$30,000 Policy Election Amount										
Employee	$30,000	$.42	$.55	$.83	$1.39	$2.08	$3.25	$5.82	$10.59	$17.45
Spouse	$15,000	$.21	$.28	$.42	$.69	$1.04	$1.63	$2.91	$5.30	$8.72
Child	$3,000	$.14	$.14	$.14	$.14	$.14	$.14	$.14	$.14	$.14
$40,000 Policy Election Amount										
Employee	$40,000	$.55	$.74	$1.11	$1.85	$2.77	$4.34	$7.75	$14.12	$23.26
Spouse	$20,000	$.28	$.37	$.55	$.92	$1.39	$2.17	$3.88	$7.06	$11.63
Child	$4,000	$.19	$.19	$.19	$.19	$.19	$.19	$.19	$.19	$.19
$50,000 Policy Election Amount										
Employee	$50,000	$.69	$.92	$1.39	$2.31	$3.46	$5.42	$9.69	$17.65	$29.08
Spouse	$25,000	$.35	$.46	$.69	$1.15	$1.73	$2.71	$4.85	$8.83	$14.54
Child	$5,000	$.23	$.23	$.23	$.23	$.23	$.23	$.23	$.23	$.23
$60,000 Policy Election Amount										
Employee	$60,000	$.83	$1.11	$1.66	$2.77	$4.15	$6.51	$11.63	$21.19	$34.89
Spouse	$30,000	$.42	$.55	$.83	$1.39	$2.08	$3.25	$5.82	$10.59	$17.45
Child	$6,000	$.28	$.28	$.28	$.28	$.28	$.28	$.28	$.28	$.28
$70,000 Policy Election Amount										
Employee	$70,000	$.97	$1.29	$1.94	$3.23	$4.85	$7.59	$13.57	$24.72	$40.71
Spouse	$35,000	$.49	$.65	$.97	$1.62	$2.42	$3.80	$6.79	$12.36	$20.35
Child	$7,000	$.32	$.32	$.32	$.32	$.32	$.32	$.32	$.32	$.32
$80,000 Policy Election Amount										
Employee	$80,000	$1.11	$1.48	$2.22	$3.69	$5.54	$8.68	$15.51	$28.25	$46.52
Spouse	$40,000	$.55	$.74	$1.11	$1.85	$2.77	$4.34	$7.75	$14.12	$23.26
Child	$8,000	$.37	$.37	$.37	$.37	$.37	$.37	$.37	$.37	$.37
$90,000 Policy Election Amount										
Employee	$90,000	$1.25	$1.66	$2.49	$4.15	$6.23	$9.76	$17.45	$31.78	$52.34
Spouse	$45,000	$.62	$.83	$1.25	$2.08	$3.12	$4.88	$8.72	$15.89	$26.17
Child	$9,000	$.42	$.42	$.42	$.42	$.42	$.42	$.42	$.42	$.42
$100,000 Policy Election Amount										
Employee	$100,000	$1.39	$1.85	$2.77	$4.62	$6.92	$10.85	$19.39	$35.31	$58.15
Spouse	$50,000	$.69	$.92	$1.39	$2.31	$3.46	$5.42	$9.69	$17.65	$29.08
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$110,000 Policy Election Amount										
Employee	$110,000	$1.52	$2.03	$3.05	$5.08	$7.62	$11.93	$21.32	$38.84	$63.97
Spouse	$55,000	$.76	$1.02	$1.52	$2.54	$3.81	$5.97	$10.66	$19.42	$31.99
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46

Voluntary Life Cost Illustration *continued*

		< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$120,000 Policy Election Amount										
Employee	$120,000	$1.66	$2.22	$3.32	$5.54	$8.31	$13.02	$23.26	$42.37	$69.79
Spouse	$60,000	$.83	$1.11	$1.66	$2.77	$4.15	$6.51	$11.63	$21.19	$34.89
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$130,000 Policy Election Amount										
Employee	$130,000	$1.80	$2.40	$3.60	$6.00	$9.00	$14.10	$25.20	$45.90	$75.60
Spouse	$65,000	$.90	$1.20	$1.80	$3.00	$4.50	$7.05	$12.60	$22.95	$37.80
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$140,000 Policy Election Amount										
Employee	$140,000	$1.94	$2.59	$3.88	$6.46	$9.69	$15.19	$27.14	$49.43	$81.42
Spouse	$70,000	$.97	$1.29	$1.94	$3.23	$4.85	$7.59	$13.57	$24.72	$40.71
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$150,000 Policy Election Amount										
Employee	$150,000	$2.08	$2.77	$4.15	$6.92	$10.39	$16.27	$29.08	$52.96	$87.23
Spouse	$75,000	$1.04	$1.39	$2.08	$3.46	$5.19	$8.14	$14.54	$26.48	$43.62
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$160,000 Policy Election Amount										
Employee	$160,000	$2.22	$2.95	$4.43	$7.39	$11.08	$17.35	$31.02	$56.49	$93.05
Spouse	$80,000	$1.11	$1.48	$2.22	$3.69	$5.54	$8.68	$15.51	$28.25	$46.52
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$170,000 Policy Election Amount										
Employee	$170,000	$2.35	$3.14	$4.71	$7.85	$11.77	$18.44	$32.95	$60.02	$98.86
Spouse	$85,000	$1.18	$1.57	$2.35	$3.92	$5.89	$9.22	$16.48	$30.01	$49.43
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$180,000 Policy Election Amount										
Employee	$180,000	$2.49	$3.32	$4.99	$8.31	$12.46	$19.52	$34.89	$63.55	$104.68
Spouse	$90,000	$1.25	$1.66	$2.49	$4.15	$6.23	$9.76	$17.45	$31.78	$52.34
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$190,000 Policy Election Amount										
Employee	$190,000	$2.63	$3.51	$5.26	$8.77	$13.15	$20.61	$36.83	$67.09	$110.49
Spouse	$95,000	$1.32	$1.75	$2.63	$4.39	$6.58	$10.30	$18.42	$33.54	$55.25
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$200,000 Policy Election Amount										
Employee	$200,000	$2.77	$3.69	$5.54	$9.23	$13.85	$21.69	$38.77	$70.62	$116.31
Spouse	$100,000	$1.39	$1.85	$2.77	$4.62	$6.92	$10.85	$19.39	$35.31	$58.15
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$210,000 Policy Election Amount										
Employee	$210,000	$2.91	$3.88	$5.82	$9.69	$14.54	$22.78	$40.71	$74.15	$122.12
Spouse	$105,000	$1.45	$1.94	$2.91	$4.85	$7.27	$11.39	$20.35	$37.07	$61.06
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$220,000 Policy Election Amount										
Employee	$220,000	$3.05	$4.06	$6.09	$10.15	$15.23	$23.86	$42.65	$77.68	$127.94
Spouse	$110,000	$1.52	$2.03	$3.05	$5.08	$7.62	$11.93	$21.32	$38.84	$63.97
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$230,000 Policy Election Amount										
Employee	$230,000	$3.19	$4.25	$6.37	$10.62	$15.92	$24.95	$44.59	$81.21	$133.75
Spouse	$115,000	$1.59	$2.12	$3.19	$5.31	$7.96	$12.47	$22.29	$40.60	$66.88
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46

Voluntary Life Cost Illustration *continued*

$240,000 Policy Election Amount										
Employee	$240,000	$3.32	$4.43	$6.65	$11.08	$16.62	$26.03	$46.52	$84.74	$139.57
Spouse	$120,000	$1.66	$2.22	$3.32	$5.54	$8.31	$13.02	$23.26	$42.37	$69.79
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$250,000 Policy Election Amount										
Employee	$250,000	$3.46	$4.62	$6.92	$11.54	$17.31	$27.12	$48.46	$88.27	$145.39
Spouse	$125,000	$1.73	$2.31	$3.46	$5.77	$8.65	$13.56	$24.23	$44.14	$72.69
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$260,000 Policy Election Amount										
Employee	$260,000	$3.60	$4.80	$7.20	$12.00	$18.00	$28.20	$50.40	$91.80	$151.20
Spouse	$130,000	$1.80	$2.40	$3.60	$6.00	$9.00	$14.10	$25.20	$45.90	$75.60
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$270,000 Policy Election Amount										
Employee	$270,000	$3.74	$4.99	$7.48	$12.46	$18.69	$29.29	$52.34	$95.33	$157.02
Spouse	$135,000	$1.87	$2.49	$3.74	$6.23	$9.35	$14.64	$26.17	$47.67	$78.51
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$280,000 Policy Election Amount										
Employee	$280,000	$3.88	$5.17	$7.75	$12.92	$19.39	$30.37	$54.28	$98.86	$162.83
Spouse	$140,000	$1.94	$2.59	$3.88	$6.46	$9.69	$15.19	$27.14	$49.43	$81.42
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$290,000 Policy Election Amount										
Employee	$290,000	$4.02	$5.35	$8.03	$13.39	$20.08	$31.45	$56.22	$102.39	$168.65
Spouse	$145,000	$2.01	$2.68	$4.02	$6.69	$10.04	$15.73	$28.11	$51.20	$84.32
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$300,000 Policy Election Amount										
Employee	$300,000	$4.15	$5.54	$8.31	$13.85	$20.77	$32.54	$58.15	$105.92	$174.46
Spouse	$150,000	$2.08	$2.77	$4.15	$6.92	$10.39	$16.27	$29.08	$52.96	$87.23
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$310,000 Policy Election Amount										
Employee	$310,000	$4.29	$5.72	$8.59	$14.31	$21.46	$33.62	$60.09	$109.45	$180.28
Spouse	$155,000	$2.15	$2.86	$4.29	$7.15	$10.73	$16.81	$30.05	$54.73	$90.14
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$320,000 Policy Election Amount										
Employee	$320,000	$4.43	$5.91	$8.86	$14.77	$22.15	$34.71	$62.03	$112.99	$186.09
Spouse	$160,000	$2.22	$2.95	$4.43	$7.39	$11.08	$17.35	$31.02	$56.49	$93.05
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$330,000 Policy Election Amount										
Employee	$330,000	$4.57	$6.09	$9.14	$15.23	$22.85	$35.79	$63.97	$116.52	$191.91
Spouse	$165,000	$2.29	$3.05	$4.57	$7.62	$11.42	$17.90	$31.99	$58.26	$95.95
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$340,000 Policy Election Amount										
Employee	$340,000	$4.71	$6.28	$9.42	$15.69	$23.54	$36.88	$65.91	$120.05	$197.72
Spouse	$170,000	$2.35	$3.14	$4.71	$7.85	$11.77	$18.44	$32.95	$60.02	$98.86
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$350,000 Policy Election Amount										
Employee	$350,000	$4.85	$6.46	$9.69	$16.15	$24.23	$37.96	$67.85	$123.58	$203.54
Spouse	$175,000	$2.42	$3.23	$4.85	$8.08	$12.12	$18.98	$33.92	$61.79	$101.77
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46

Voluntary Life Cost Illustration *continued*

$360,000 Policy Election Amount										
Employee	$360,000	$4.99	$6.65	$9.97	$16.62	$24.92	$39.05	$69.79	$127.11	$209.35
Spouse	$180,000	$2.49	$3.32	$4.99	$8.31	$12.46	$19.52	$34.89	$63.55	$104.68
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$370,000 Policy Election Amount										
Employee	$370,000	$5.12	$6.83	$10.25	$17.08	$25.62	$40.13	$71.72	$130.64	$215.17
Spouse	$185,000	$2.56	$3.42	$5.12	$8.54	$12.81	$20.07	$35.86	$65.32	$107.59
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$380,000 Policy Election Amount										
Employee	$380,000	$5.26	$7.02	$10.52	$17.54	$26.31	$41.22	$73.66	$134.17	$220.99
Spouse	$190,000	$2.63	$3.51	$5.26	$8.77	$13.15	$20.61	$36.83	$67.09	$110.49
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$390,000 Policy Election Amount										
Employee	$390,000	$5.40	$7.20	$10.80	$18.00	$27.00	$42.30	$75.60	$137.70	$226.80
Spouse	$195,000	$2.70	$3.60	$5.40	$9.00	$13.50	$21.15	$37.80	$68.85	$113.40
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$400,000 Policy Election Amount										
Employee	$400,000	$5.54	$7.39	$11.08	$18.46	$27.69	$43.39	$77.54	$141.23	$232.62
Spouse	$200,000	$2.77	$3.69	$5.54	$9.23	$13.85	$21.69	$38.77	$70.62	$116.31
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$410,000 Policy Election Amount										
Employee	$410,000	$5.68	$7.57	$11.35	$18.92	$28.39	$44.47	$79.48	$144.76	$238.43
Spouse	$205,000	$2.84	$3.79	$5.68	$9.46	$14.19	$22.24	$39.74	$72.38	$119.22
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$420,000 Policy Election Amount										
Employee	$420,000	$5.82	$7.75	$11.63	$19.39	$29.08	$45.55	$81.42	$148.29	$244.25
Spouse	$210,000	$2.91	$3.88	$5.82	$9.69	$14.54	$22.78	$40.71	$74.15	$122.12
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$430,000 Policy Election Amount										
Employee	$430,000	$5.95	$7.94	$11.91	$19.85	$29.77	$46.64	$83.35	$151.82	$250.06
Spouse	$215,000	$2.98	$3.97	$5.95	$9.92	$14.89	$23.32	$41.68	$75.91	$125.03
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$440,000 Policy Election Amount										
Employee	$440,000	$6.09	$8.12	$12.19	$20.31	$30.46	$47.72	$85.29	$155.35	$255.88
Spouse	$220,000	$3.05	$4.06	$6.09	$10.15	$15.23	$23.86	$42.65	$77.68	$127.94
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$450,000 Policy Election Amount										
Employee	$450,000	$6.23	$8.31	$12.46	$20.77	$31.15	$48.81	$87.23	$158.89	$261.69
Spouse	$225,000	$3.12	$4.15	$6.23	$10.39	$15.58	$24.40	$43.62	$79.44	$130.85
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$460,000 Policy Election Amount										
Employee	$460,000	$6.37	$8.49	$12.74	$21.23	$31.85	$49.89	$89.17	$162.42	$267.51
Spouse	$230,000	$3.19	$4.25	$6.37	$10.62	$15.92	$24.95	$44.59	$81.21	$133.75
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$470,000 Policy Election Amount										
Employee	$470,000	$6.51	$8.68	$13.02	$21.69	$32.54	$50.98	$91.11	$165.95	$273.32
Spouse	$235,000	$3.25	$4.34	$6.51	$10.85	$16.27	$25.49	$45.55	$82.97	$136.66
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46

Voluntary Life Cost Illustration *continued*

$480,000 Policy Election Amount										
Employee	$480,000	$6.65	$8.86	$13.29	$22.15	$33.23	$52.06	$93.05	$169.48	$279.14
Spouse	$240,000	$3.32	$4.43	$6.65	$11.08	$16.62	$26.03	$46.52	$84.74	$139.57
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$490,000 Policy Election Amount										
Employee	$490,000	$6.79	$9.05	$13.57	$22.62	$33.92	$53.15	$94.99	$173.01	$284.95
Spouse	$245,000	$3.39	$4.52	$6.79	$11.31	$16.96	$26.57	$47.49	$86.50	$142.48
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46
$500,000 Policy Election Amount										
Employee	$500,000	$6.92	$9.23	$13.85	$23.08	$34.62	$54.23	$96.92	$176.54	$290.77
Spouse	$250,000	$3.46	$4.62	$6.92	$11.54	$17.31	$27.12	$48.46	$88.27	$145.39
Child	$10,000	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46	$.46

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.

Premiums for Voluntary Life Increase in five-year increments

Infant coverage is limited for the first two weeks of infant's life.

‡**Spouse coverage premium is based on Employee age. Coverage for the spouse terminates at spouse's age 70.**

†Benefit reductions apply.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00379860

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

Voluntary Life Only:

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-LB-90, GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties er on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Enhanced AD&D: A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Accidental Death and Dismemberment Benefit Summary

Group Number: 00379860

About Your Benefits:

AD&D coverage provides additional benefits following an accidental death or certain bodily injuries.

What Your Benefits Cover:

COVERAGE OPTIONS	ENHANCED ACCIDENTAL DEATH & DISMEMBERMENT
Employee benefit	$10,000 increments to a maximum of $500,000. See Cost Illustration page for details.

Benefit Reductions—Please be aware that your Benefit Amount may decrease as shown below:

35 % at Age 65
60 % at Age 70
75 % at Age 75
85 % at Age 80

Subject to coverage limits

Enhanced AD&D Features Include: Child Education Benefit, Education & Retraining Benefit, Seatbelt & Airbag Benefit, Day Care Expense, Repatriation, and Common Carrier.

Accidental Death and Dismemberment Life Cost Illustration:

AD&D coverage provides additional benefits following an accidental death or certain bodily injuries.

Employee Policy Election Amount	Weekly Premiums displayed
$10,000	$0.09
$20,000	$0.19
$30,000	$0.28
$40,000	$0.37
$50,000	$0.46
$60,000	$0.55
$70,000	$0.65
$80,000	$0.74
$90,000	$0.83
$100,000	$0.92
$110,000	$1.02
$120,000	$1.11
$130,000	$1.20
$140,000	$1.29
$150,000	$1.39
$160,000	$1.48
$170,000	$1.57
$180,000	$1.66
$190,000	$1.75
$200,000	$1.85
$210,000	$1.94
$500,000	$4.62

Benefit reductions apply.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00379860

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATION AND EXCLUSIONS FOR AD&D

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. This proposal is hedged subject to satisfactory financial evaluation. Please refer to policy booklet for full plan description.

We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated.

The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Enhanced AD&D: A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustration purposes only and is an approximation, premium amounts may be amended.

Disability Benefit Summary

Group Number: 00379860

About Your Benefits:

You probably have insurance for your car or home, but what about the source of income that pays for it? You rely on your paycheck for so many things, but what if you were suddenly unable to work due to an accident or illness? How will you put food on the table, pay your mortgage or heat your home? Disability insurance can help replace lost income and make a difficult time a little easier. Protect your most valuable asset, your paycheck-enroll today!

What Your Benefits Cover:

	Short-Term Disability	Long-Term Disability
Coverage amount	60% of salary to maximum $1150/week	60% of salary to maximum $5000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	26 weeks	To age 65, standard ADEA
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 14	Day 181
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 14	Day 181
Conversion: Allows you to continue disability coverage after your group plan has terminated.	Not Available	Yes
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $1150 in coverage	We Guarantee Issue $5000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after 2 week limitation	6 months look back; 24 months after exclusion
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes	Yes
Survivor benefit: Additional benefit payable to your family if you die while disabled.	No	3 months

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Disability (short-term):** Employee is considered disabled if unable to perform major job duties on a full-time basis. Employee is not considered disabled if able to perform any work for wage or profit.
- **Disability (long-term):** For first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
- **Earnings definition:** Your covered salary is based on your previous year's W2 statement.
- **Special limitations:** Provides a 24-month benefit limit for specific conditions including mental health and substance abuse. Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

Disability Cost Illustration:

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses. To help you assess your needs, you can also go to Guardian Anytime and view a video:
https://www.guardiananytime.com/gafd/wps/portal/fdhome/employees/products-coverage/disability

Short-Term Disability Plan Weekly Cost Illustration:

Policy amounts shown based on sample salary amounts only.

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
Your premium rate	$0.520	$0.520	$0.520	$0.520	$0.520	$0.520	$0.520	$0.520	$0.520
					Election Cost Per Age Bracket				
	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
$10,000 Annual Salary $115 Weekly Benefit	$1.38	$1.38	$1.38	$1.38	$1.38	$1.38	$1.38	$1.38	$1.38
$20,000 Annual Salary $231 Weekly Benefit	$2.77	$2.77	$2.77	$2.77	$2.77	$2.77	$2.77	$2.77	$2.77
$30,000 Annual Salary $346 Weekly Benefit	$4.15	$4.15	$4.15	$4.15	$4.15	$4.15	$4.15	$4.15	$4.15
$40,000 Annual Salary $462 Weekly Benefit	$5.54	$5.54	$5.54	$5.54	$5.54	$5.54	$5.54	$5.54	$5.54
$50,000 Annual Salary $577 Weekly Benefit	$6.92	$6.92	$6.92	$6.92	$6.92	$6.92	$6.92	$6.92	$6.92
$60,000 Annual Salary $692 Weekly Benefit	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30
$70,000 Annual Salary $808 Weekly Benefit	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70
$80,000 Annual Salary $923 Weekly Benefit	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08
$90,000 Annual Salary $1,038 Weekly Benefit	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46
$100,000 Annual Salary $1,150 Weekly Benefit	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80
$60,000 Annual Salary $692 Weekly Benefit	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30	$8.30
$65,000 Annual Salary $750 Weekly Benefit	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00
$70,000 Annual Salary $808 Weekly Benefit	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70	$9.70
$75,000 Annual Salary $865 Weekly Benefit	$10.38	$10.38	$10.38	$10.38	$10.38	$10.38	$10.38	$10.38	$10.38
$80,000 Annual Salary $923 Weekly Benefit	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08	$11.08
$85,000 Annual Salary $981 Weekly Benefit	$11.77	$11.77	$11.77	$11.77	$11.77	$11.77	$11.77	$11.77	$11.77
$90,000 Annual Salary $1,038 Weekly Benefit	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46	$12.46

	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
$95,000 Annual Salary $1,096 Weekly Benefit	$13.15	$13.15	$13.15	$13.15	$13.15	$13.15	$13.15	$13.15	$13.15
$100,000 Annual Salary $1,150 Weekly Benefit	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80
$105,000 Annual Salary $1,150 Weekly Benefit	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80
$110,000 Annual Salary $1,150 Weekly Benefit	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80
$115,000 Annual Salary $1,150 Weekly Benefit	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80	$13.80

Long-Term Disability Plan Weekly Cost Illustration:

Policy amounts shown based on sample salary amounts only.

	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
Your premium rate	$0.080	$0.080	$0.130	$0.160	$0.290	$0.550	$0.810	$0.910	$0.600

	Election Cost Per Age Bracket								
	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
$10,000 Annual Salary $500 Monthly Benefit	$0.15	$0.15	$0.25	$0.31	$0.56	$1.06	$1.56	$1.75	$1.15
$15,000 Annual Salary $750 Monthly Benefit	$0.23	$0.23	$0.38	$0.46	$0.84	$1.59	$2.34	$2.63	$1.73
$20,000 Annual Salary $1,000 Monthly Benefit	$0.31	$0.31	$0.50	$0.62	$1.12	$2.12	$3.12	$3.50	$2.31
$25,000 Annual Salary $1,250 Monthly Benefit	$0.39	$0.39	$0.63	$0.77	$1.39	$2.64	$3.89	$4.37	$2.88
$30,000 Annual Salary $1,500 Monthly Benefit	$0.46	$0.46	$0.75	$0.92	$1.67	$3.17	$4.67	$5.25	$3.46
$35,000 Annual Salary $1,750 Monthly Benefit	$0.54	$0.54	$0.88	$1.08	$1.95	$3.70	$5.45	$6.13	$4.04
$40,000 Annual Salary $2,000 Monthly Benefit	$0.62	$0.62	$1.00	$1.23	$2.23	$4.23	$6.23	$7.00	$4.62
$45,000 Annual Salary $2,250 Monthly Benefit	$0.69	$0.69	$1.13	$1.39	$2.51	$4.76	$7.01	$7.88	$5.19
$50,000 Annual Salary $2,500 Monthly Benefit	$0.77	$0.77	$1.25	$1.54	$2.79	$5.29	$7.79	$8.75	$5.77
$55,000 Annual Salary $2,750 Monthly Benefit	$0.85	$0.85	$1.38	$1.69	$3.07	$5.82	$8.57	$9.62	$6.35
$60,000 Annual Salary $3,000 Monthly Benefit	$0.92	$0.92	$1.50	$1.85	$3.35	$6.35	$9.35	$10.50	$6.92
$65,000 Annual Salary $3,250 Monthly Benefit	$1.00	$1.00	$1.63	$2.00	$3.63	$6.88	$10.13	$11.38	$7.50
$70,000 Annual Salary $3,500 Monthly Benefit	$1.08	$1.08	$1.75	$2.15	$3.90	$7.40	$10.90	$12.25	$8.08

	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
$75,000 Annual Salary $3,750 Monthly Benefit	$1.15	$1.15	$1.88	$2.31	$4.18	$7.93	$11.68	$13.13	$8.65
$80,000 Annual Salary $4,000 Monthly Benefit	$1.23	$1.23	$2.00	$2.46	$4.46	$8.46	$12.46	$14.00	$9.23
$85,000 Annual Salary $4,250 Monthly Benefit	$1.31	$1.31	$2.13	$2.62	$4.74	$8.99	$13.24	$14.87	$9.81
$90,000 Annual Salary $4,500 Monthly Benefit	$1.39	$1.39	$2.25	$2.77	$5.02	$9.52	$14.02	$15.75	$10.39
$95,000 Annual Salary $4,750 Monthly Benefit	$1.46	$1.46	$2.38	$2.92	$5.30	$10.05	$14.80	$16.63	$10.96
$100,000 Annual Salary $5,000 Monthly Benefit	$1.54	$1.54	$2.50	$3.08	$5.58	$10.58	$15.58	$17.50	$11.54
$105,000 Annual Salary $5,000 Monthly Benefit	$1.54	$1.54	$2.50	$3.08	$5.58	$10.58	$15.58	$17.50	$11.54
$110,000 Annual Salary $5,000 Monthly Benefit	$1.54	$1.54	$2.50	$3.08	$5.58	$10.58	$15.58	$17.50	$11.54
$115,000 Annual Salary $5,000 Monthly Benefit	$1.54	$1.54	$2.50	$3.08	$5.58	$10.58	$15.58	$17.50	$11.54

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00379860

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Long-Term Disability coverage, we pay no benefits for a disability caused or contributed to by a pre-existing condition unless the disability starts after you have been insured under this plan for a specified period of time. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse.
- For Short-Term Disability coverage, benefits for a disability caused or contributed to by a pre-existing condition are limited, unless the disability starts after you have been insured under this plan for a specified period of time. We do not pay short term disability benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA.

  Contract #.s GP-1-STD94-1.0 et al; GP-1-STD2K-1.0 et al; GP-1-STD07-1.0 et al; GP-1-STD-15-1.0 et al. Contract #.s GP-1-LTD94-A,B,C-1.0 et al.; GP-1-LTD2K-1.0 et al; GP-1-LTD07-1.0 et al; GP-1-LTD-15-1.0 et al.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Group Number: 00379860

Accident Benefit Summary

About Your Benefits:

Accidents happen every day. Did you know almost 39 Million emergency room visits a year are due to an injury?[1] If you were injured from an accident, chances are you will have expenses that you were not anticipating-will you be prepared? Accident Insurance can help you deal with those expenses. Benefit payments can help you with your medical deductibles and co-pays, and cover household expenses like groceries, mortgage payments and childcare, which can begin to pile up if you have to take some time off from work. You are guaranteed coverage, so please enroll today!

[1]Injury Facts, 2011 Edition, National Safety Council.

What Your Benefits Cover:

	ACCIDENT
COVERAGE - DETAILS	
Your Weekly premium	$3.00
You and Spouse	$5.29
You and Child(ren)	$5.62
You, Spouse and Child(ren)	$7.90
Accident Coverage Type	On and Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment. Ported Accident plan terminates at age 70.	Included
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Accident Emergency Room Treatment	$150
Accident Follow-Up Visit - Doctor	$25 up to 6 treatments
Air Ambulance	$500
Ambulance	$100
Appliance - Wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck.	$100
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burn - Skin Graft	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate.	20% increase to child benefits
Coma	$7,500
Concussions	$50
Dislocations	Schedule up to $3,600
Diagnostic Exam (Major)	$100
Emergency Dental Work	$200/Crown, $50/Extraction
Epidural pain management	$100, 2 times per accident
Eye Injury	$200

FEATURES (Cont.)	
Family Care	$20/day up to 30 days
Fracture	Schedule up to $4,500
Hospital Admission	$750
Hospital Confinement	$175/day - up to 1 year
Hospital ICU Admission	$1,500
Hospital ICU Confinement	$350/day - up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$50
Joint Replacement (hip/knee/shoulder)	$1,500/$750/$750
Knee Cartilage	$500
Laceration	Schedule up to $300
Lodging - The hospital must be more than 50 miles from the insured's residence.	$100/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$25/day up to 10 days
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$150/day up to 15 days
Ruptured Disc With Surgical Repair	$500
Surgery	Schedule up to $1,000 Hernia: $125
Surgery - Exploratory or Arthroscopic	$150
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$400, 3 times per accident
X - Ray	$20

UNDERSTANDING YOUR BENEFITS:

- **Accident Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00379860

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

This plan will not pay benefits for any injury caused by or related to: declared or undeclared war, act of war or armed aggression; taking part in a riot or civil disorder; or commission of, or attempt to commit a felony; intentionally self inflicted injury, while sane or insane; suicide, while sane or insane. The covered person being legally intoxicated. Treatment rendered or hospital confinement outside the United States or Canada. Travel of flight in any kind of aircraft including any aircraft owned by or for the employer except as a fare paying passenger on a common carrier. Participation in any kind of sporting activity for compensation or profit including coaching or officiating.

Riding in or driving any motor-driven vehicle in a race, stunt show or speed test. Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting, ballooning, parachuting, and/or skydiving. Injuries to a dependent child received during the birth. An accident that occurred before the covered person is covered by this plan. Sickness, disease, mental infirmity or medical or surgical treatment.

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Accident Coverage – Value Benefit

Children play to win. Our coverage plays it smart.

Unique benefit with Guardian Accident Insurance

It's important to encourage children to be active. And millions of children find an answer in organized sports — whether it's Little League, soccer or football. But accidents happen. Luckily, Guardian Accident Insurance has it covered:

Benefits are increased by 20% if a covered dependent child (aged 18 years old or younger) is injured while participating in an organized sport.*

For instance, imagine your child has a collision in the outfield while playing baseball. He's taken to the hospital in an ambulance and given an MRI to check for injuries. He ends up staying overnight for observation because the MRI confirmed a concussion. Here's the breakdown of what Guardian covers, along with the additional Child Organized Sport benefit.

PROCEDURE	GUARDIAN ACCIDENT INSURANCE BENEFIT	ADDITIONAL CHILD ORGANIZED SPORT ADVANTAGE BENEFIT
Ambulance ride	$100	$20
Emergency Room visit	$150	$30
Hospital admission (his stay was over 20 hours)	$750	$150
MRI	$100	$20
Concussion	$50	$10
2 follow-up doctor visits	$25 X 2 = $50	$10
TOTAL BENEFIT	$1,200	$240
GRAND TOTAL	**$1,440.00**	

Enroll in Accident coverage today.

* Proof of registration required at time of claim

Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

WorkLifeMatters

Your Confidential Employee Assistance Program – Helping find balance between work and home life.

WorkLifeMatters provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- **Unlimited free telephonic consultation with an EAP counselor available 24/7 at 800-386-7055**
- **Referrals to local counselors — up to three sessions free of charge**
- **State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center**

WorkLifeMatters can offer help with:

Education
- Admissions testing & procedures
- Adult re-entry programs
- College Planning
- Financial aid resources
- Finding a pre-school

Dependent Care & Care Giving
- Adoption Assistance
- Before/after school programs
- Day Care/Elder Care
- Elder care
- In-home services

Legal and financial
- Basic tax planning
- Credit & collections
- Debt Counseling
- Home buying
- Immigration

Lifestyle & Fitness Management
- Anxiety & depression
- Divorce & separation
- Drugs & alcohol

Working Smarter
- Career development
- Effective managing
- Relocation

For more information about WorkLifeMatters, go to www.ibhworklife.com; User Name: Matters; Password: wlm70101

WillPrep Services

Special bonus for participants in voluntary life plan

Your employer has worked with Guardian to make WillPrep Services available to eligible members with Voluntary Life plans. Keeping an up-to-date will is essential to ensuring that your assets are distributed as you intended, no matter the size of your estate. You may be avoiding creating a will because you believe you can't afford the time or legal expense. Now you can with WillPrep Services.

WillPrep Services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep has a range of services including online planning documents, a resource library and access to professionals* to help with issues related to:

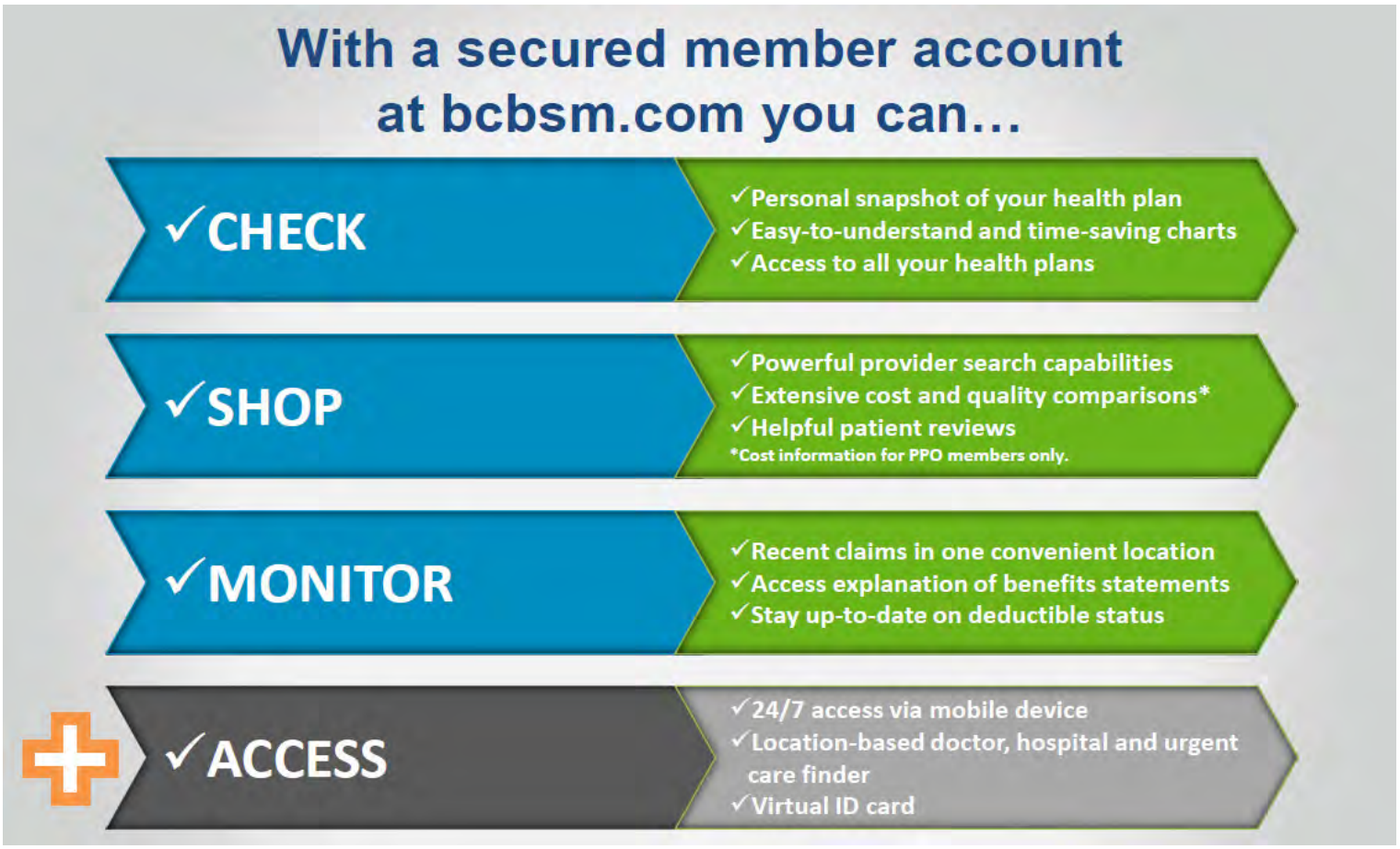
▪ Advanced Health Care Directives	▪ Financial Power of Attorney	▪ Wills and Living Wills
▪ Estate Taxes	▪ Guardianship and Conservatorship	▪ Resource Library
▪ Executors & Probate	▪ Healthcare Power of Attorney	▪ Trusts

For more information about WillPrep Services, go to www.ibhwillprep.com; User name: WillPrep; Password: GLIC09 or call 1-877-433-6789

*The Option of an attorney prepared will is available for a small fee.
WillPrep Services are provided by Integrated Behavioral Health, Inc., and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of *WillPrep Services*. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the *WillPrep Services* at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

Additional Resources

All the information you need to manage your health care plan is at your fingertips at www.bcbsm.com under the member portal.



HEALTHY SAVINGS

healthybluextras℠
good for you. good for michigan.

Healthy Blue Xtras is a savings program that provides members of the Michigan Blues with special savings on health-related products and services they use every day. The vendors participating in the program are Michigan based, and are providing these savings at no cost to Michigan Blues members. The theme line, "Good for You. Good for Michigan," identifies it as a Michigan-based program.

There is no cost to members for the discounts. There will be new vendors added each month in the categories of Health & Fitness, Food & Nutrition, Home & Garden, Travel, General, and Recreation so

24/7 ONLINE HEALTHCARE

BCBSM/BCN offers fast, convenient, affordable online health care 24 hours a day, seven days a week, from almost anywhere in the U.S. If your doctor is not available, you're on vacation, you can't leave work or your house, you can be seen by an online doctor for the cost of an office visit for minor, nonemergency illness such as these:

* *Sinus and respiratory infections*	* *Vomiting*	* *Strains and Sprains*	* *Pinkeye*
* *Colds, flu and seasonal allergies*	* *Diarrhea*	* *Urinary Tract Infections*	* *Headache*

Please refer to the next page for additional information on this convenient online health care service available to you and your family members.

Discover wellness through **Blue Cross® Health & Wellness; Powered by WebMD** Up-to-date health information and online tools designed specifically to help you achieve and maintain a healthy lifestyle.

- *Online Wellness Platform*
- *24 Hour Nurse Line*
- *Engagement Center*
- *Case Management*
- *Complex Chronic Condition Management*
- *Win by Losing*

Blue Cross Blue Shield Blue Care Network of Michigan

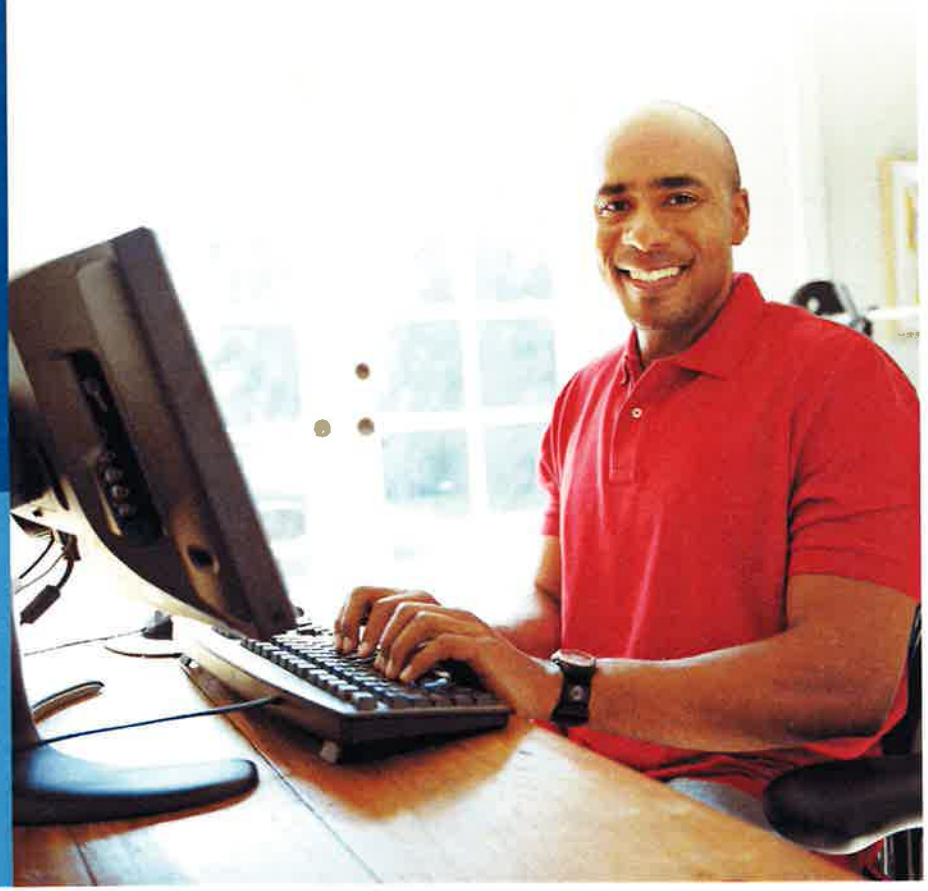
Shop for care at **bcbsm.com**

A GUIDE TO COMPARING AND CHOOSING HEALTH CARE PROVIDERS

You want more control when it comes to making your health care decisions, and we're committed to helping you with tools, information and personal support at **bcbsm.com**.

With **bcbsm.com**, you get everything you need to put you in charge of choosing your health care providers and managing your health care costs. And you'll find the information and tools online — all in one convenient location.

You can search for doctors, specialists and medical facilities using *Find a Doctor* at **bcbsm.com**. Use this handy guide to help you easily find what you need.



FIND A DOCTOR

Find a Doctor gives you a complete look at health care costs. It automatically pulls in information based on your selected plan, when logged in to your member account. You can:

- Search for doctors or facilities specifically in your plan's network.
- Select a primary care physician (if applicable).
- Compare cost estimates for health care treatment and services.*
- Read *and* write reviews about doctors.
- See doctor and hospital quality reports.

GETTING STARTED

Using your desktop computer.

1. Log in to your member account at **bcbsm.com**. (Screens highlighted in this brochure may differ slightly if you're using a mobile device.)
2. Select the *Doctors & Hospitals* tab to be directed to *Find a Doctor*.
3. Choose the *Find a Doctor or Hospital, Compare Cost and Quality* category.

*Non-Medicare, PPO members

BEGIN YOUR SEARCH FOR PROVIDERS

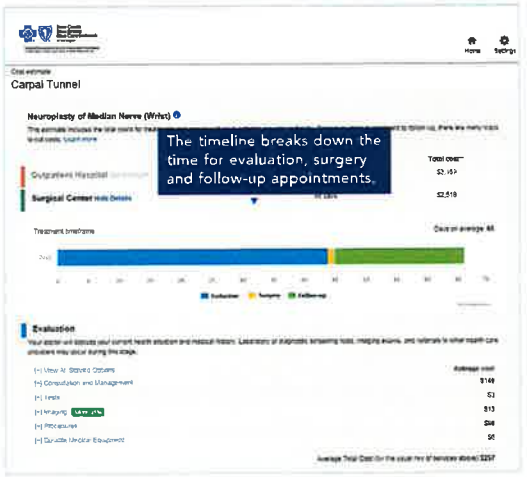
Find a Doctor automatically enters your plan and nearest location. You'll need to type the name of the doctor, specialty or service in to the search field. You can also change the location by city or ZIP code based on how broad you want to search. Click the *Search*, and you'll see a list of doctors that are within your plan's network.

COMPARE PROCEDURES BY COSTS

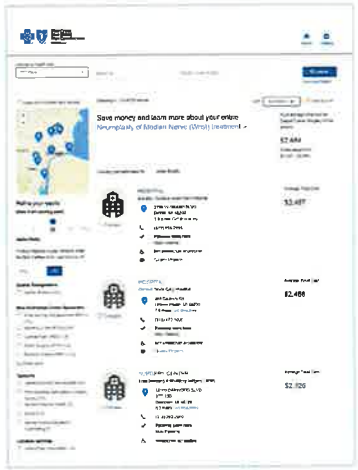
Where you go for care does affect how much you'll spend on health care, but you can find ways to save on costs with *Find a Doctor*.

Let's say your doctor recommends surgery. You're not limited to using your doctor's facility. Using *Find a Doctor*, you can compare costs between services in hospital and non-hospital settings, giving you opportunities to save money.

Your member account gives you an idea of what the full procedure will cost. A timeline shows all the services involved for overall treatment and each of their costs.



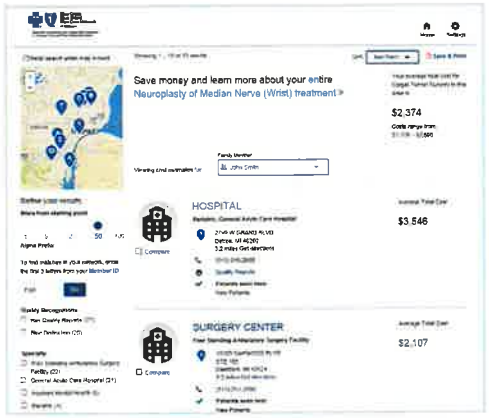
If you have Blue Cross PPO coverage you can also look up more than 1,600 specific health care services across the country.



Look up the costs of 1,600 specific health care services, if you have Blue Cross PPO coverage.

COMPARE PROVIDERS

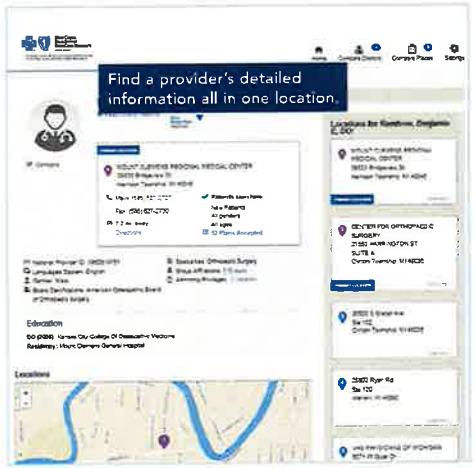
Narrow your choice of physicians by selecting items that mean the most to you. You'll get a list of providers that best match your search criteria. You can even read patient reviews on each provider.



Select the factors that are important to you.

Click on the doctor's name for detailed information including:

- Office location and hours
- Plans accepted
- Gender
- Languages spoken
- Specialties
- Group and hospital affiliations
- Board certifications
- Education
- Quality reports



View up to five providers side by side, when you check the *Compare* box next to each provider's listing in your results.

REGISTER NOW — AND GET THE POWER YOU NEED FOR SMART HEALTH CHOICES

Go to **bcbsm.com/register** and have your Blue Cross or Blue Care Network ID card ready.

And, visit **bcbsm.com/understandcost** to learn more about shopping for care.

Emergency Room vs. Urgent Care

Every day, many people visit emergency rooms (ERs) who could have been better candidates for treatment at an urgent care facility. ERs and urgent care centers both offer after-hours care for unexpected medical situations that need immediate attention, and determining which of these facilities is appropriate to your immediate medical needs can save you time and money. ERs are better equipped to handle life-threatening injuries and illnesses, and other serious medical conditions such as difficulty breathing or sudden, severe pain. Patients at the ER are sorted, or triaged, according to the seriousness of their conditions. For example, a patient with severe injuries from a car accident would likely be seen before a child with an ear infection, even if the child was brought in first. To determine whether to visit the ER or urgent care, consider the list below.

Urgent care is adequate for:

- Sprains
- Ear infections
- Urinary tract infections
- Vomiting
- Cold or flu symptoms
- High fever

Go to the ER if you are experiencing any of the following symptoms:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Broken bones
- Seizures
- Paralysis
- Suspected poisoning
- Severe abdominal pain following an injury
- Loss of consciousness or confusion, especially if after a head injury

Stretching Your Dollars at the Pharmacy

As prescription drug costs rise, you probably feel the pinch in your wallet. But there are some simple things you can do to help save money on your prescriptions.

- Be sure to ask your doctor about other medication options, for example, OTC medications. Sometimes these can be just as effective.
- Generic versions of brand-name drugs are much less expensive, and the FDA requires that generic drugs meet the same stringent guidelines as all brand-name drugs.
- **Rx Savings programs** - Check with your local retail Pharmacy such as Wal-Mart, Kroger, Sam's Club and Target as they offer a wide range of generic prescription drugs ranging from only $4 to $10.
- You can check for generic equivalents to your prescriptions using **Medtipster** at www.medtipster.com. Here you can type in the name of your medication, dosage & your zip code & find affordable equivalents in your area.
- If there is no generic version available of the drug you are prescribed, ask your doctor if there is a less expensive brand-name you could try instead.
- Sometimes splitting high dosage tablets or capsules in half can save you more money than taking a whole pill of a low dose. However, some medications become ineffective when split, so make sure to check with your doctor before asking about this option.
- Check if your doctor has any free samples that you could have.
- **Another useful website you can use to learn more about ways to save on your prescription medications are www.needymeds.org or http://www.michigandrugprices.com/Discount**

Below is a list of common terms used by the insurance plans. Please note that these are generic terms, that may or may not apply to your coverage. Please refer to your plan booklets for your specific plan information.

Accelerated Benefit (also referred to as Living Benefit): An optional provision under a life policy that allows the insured to receive the benefit prior to death if the insured has a terminal illness or serious injury requiring long term care.

Creditable Coverage: Under HIPAA, the period of an individual's coverage under a Group Health Plan, health insurance, Medicare or any one of several other specified health plans or health insurance sources that is not interrupted by a significant break in coverage (generally, a 63 day period).

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 which requires group health plans to provide employees and eligible family members the opportunity to continue health care coverage at their own expense, when coverage would be lost under certain circumstances.

Coinsurance: a cost sharing arrangement under an insured health plan under which a covered person pays a specified percentage of the cost of a specified service, such as 20% of the cost of a doctor's visit.

Conversion: An optional provision that allows insured to convert their terminated group plan to an individual plan (in most cases the benefit level and rates will change).

Deductible: The amount that a person must pay towards covered benefits before any benefits are payable from a health plan.

Exchange: A health insurance marketplace that makes available Qualified Health Plans (QHPs) to qualified individuals and employers

Formulary: A list of prescription drugs covered by the plan, and the tier that each drug falls under (i.e. generic, brand name). The formulary is based on evaluations of efficacy, safety and cost-effectiveness of drugs.

Generic Drug: A term used to describe an identical or bioequivalent medication to a brand name medications in dosage form, safety, strength, route of administration, quality, performance and intended use.

Network Provider: Physicians, hospitals, or other health care providers/facilities who contract with the insurance carrier to provide services to its members.

Non-Network Provider: Physicians, hospitals, or other health care providers/facilities who DO NOT have a contract with the insurance carrier to provide services to its members. Depending on the plan, services provided by non-network providers may not be covered, or covered at a lower benefit.

Out-of-Pocket Medical Expenses: Copayments, deductibles and medical expenses that are not covered by the employer's major medical plan.

Portability: An optional provision that allows the insured to continue a group benefit directly through the carrier (in most cases at a similar benefit level and rate).

Preventive Care: Services that are for prevention, not for the treatment of active diseases or illnesses such as routine physical exams and or some screenings.

Reasonable and Customary (also referred to as UCR): Fees paid by an insurance plan for a specific procedure within a specified geographic area. If your provider is a non-network provider and charges more than the R &C you may be responsible for paying the additional amount (this is also referred to as balance billing).

Waiting Period: The period that must pass before an employee or dependent is eligible to enroll (becomes covered) under the terms of the group health plan.

Insurance Carrier	Policy	Phone Number	Website
Blue Cross Blue Shield Blue Care Network of Michigan	Medical	BCBSM (800) 637-2227 BCN (800) 662-6667	www.bcbsm.com
	Dental	(888) 826-8152.	www.mibluedentist.com
	Vision	(800) 877-7195	www.vsp.com
BCBSM Online Visits	24/7 Online Health	(844) 606-1608	**Download the app** www.bcbsmonlinevisits.com
GUARDIAN®	Life/AD&D STD/LTD	(888) 600-1600	www.GuardianAnytime.com
	Employee Assistance Program	(800) 386-7055	www.ibhworklife.com Username: matters Password: wlm070101
	Will Prep Services (Offered with Voluntary Life ONLY)	(877) 433-6789	www.GuardianLife.com Username: WillPrep Password: GLIC09
epitec Placing People First	Support Team	(248) 864-7215	portal.epitec.com