

## MEDICAL CARE BENEFITS

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**IMPORTANT NOTICE:** Federal law requires every employer to notify each covered employee and dependent(s) of their continuation of coverage rights after termination of employment. Your rights regarding continuation of coverage can be found on page 9 of this booklet.

EMPLOYER DATA SCHEDULE  
MEDICAL CARE BENEFITS PLAN

Effective Date: August 1, 1988  
**Revision:** July 1, 2003

Group Number: 4

Employer: Bay Arenac ISD  
4228 Two Mile Rd  
Bay City, Michigan 48706  
Telephone: (989) 667-3251

Eligible Class(s): Administrators & Non-Certified Staff, Steelworkers, the Academic, Technical and Administrative Support Group, Service Employees Association and Local 4580 MFT.

Service Requirement: Date of Hire

"Actively At Work" Requirement: Full-time Employees or part time employees who work on a regularly scheduled basis per employment or bargaining unit agreement.

Employee Contributions: Per employment or bargaining unit agreement.

Annual Open Enrollment Period: Month of September, effective January

Benefit Period: January through December

Coordination of Benefits: Standard

Assignment of Benefits: Included

Plan Year: The records of the Plan are kept separately for each Plan Year. The Plan Year begins on July 1, and ends on June 30.

**CMM WRAP PPO**

**SCHEDULE OF BENEFITS  
for  
BAY ARENAC ISD**

| <b>BENEFITS</b>  | <b>ANNUAL<br/>DEDUCTIBLE</b> | <b>PLAN COPAYMENT</b>                                |
|--|------------------------------|--|
| <b><i>Inpatient Hospital Care</i></b>  |                              |  |
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies                            | \$-0-                        | 100% 365 day limit, subject to extended stay review. |
| Inpatient Consultations  | \$-0-                        | 100% MPL   |
| <b><i>Outpatient Hospital Care -<br/>Emergency Room</i></b>  |                              |  |
| Accidental (Emergent situations only - must be approved diagnosis)   | \$-0-                        | 100% MPL   |
| Medical Emergencies (Emergent situations only - must be approved diagnosis)  | \$-0-                        | 100% MPL   |
| Physical Therapy   | \$50/\$100                   | 90% MPL  |
| Non-Emergent Emergency Rooms (including Physician)   | \$50/\$100                   | 90% MPL  |
| <b><i>Mental Health Care and Substance Abuse</i></b>   |                              |  |
| Inpatient Mental Health Care (unlimited days, up to state maximum)   | \$-0-                        | 100% MPL   |
| Inpatient Substance Abuse Care (unlimited days, up to state maximum)   | \$-0-                        | 100% MPL   |
| Outpatient Mental Health Care (50 visits annually)   |                              |  |
| * Facility and Clinic  | \$50/\$100                   | 90% MPL  |
| * Physician's Office   | \$50/\$100                   | 90% MPL  |
| Outpatient Substance Abuse Care (35 visits annually)   | \$-0-                        | 100% MPL   |
| <b><i>Mammography Screening</i></b>  |                              |  |
| Mammography Screening (age restrictions apply)   | \$-0-                        | 100% MPL   |
| <b><i>Special Hospital/Facility Programs</i></b>   |                              |  |
| Home Health Care   | \$-0-                        | 100% MPL   |
| Hospice-approved facilities  | \$-0-                        | 100% MPL   |
| Individual Case Management   | \$-0-                        | 100% MPL   |
| <b><i>Human Organ Transplants</i></b>  |                              |  |
| Liver, Heart, Lung, Pancreas, and Heart-Lung (up to One Million Dollar maximum per transplant with a 9-month waiting period) | \$-0-                        | 100% MPL   |
| Kidney, Cornea, Skin and Bone Marrow   | \$-0-                        | 100% MPL   |

**Medical/Surgical Care**

Surgery, including all related surgical services, anesthesia, and surgical assistance (approved facility only) 100% MPL

Voluntary Sterilization \$-0- 100% MPL

**Maternity Services Provided by a Physician**

Pre-and Post-Natal Care \$-0- 100% MPL

Delivery and Nursery Care \$-0- 100% MPL

**Emergency Medical Care**

Hospital Emergency Room - with BCBSM approved diagnosis \$-0- 100% MPL

Physician's Office - with BCBSM approved diagnosis \$-0- 100% MPL

Ambulance Services - Ground (Air Ambulance Service covered only when serious injury is involved and to the nearest facility) \$-0- 100% MPL

**Diagnostic Services**

Laboratory and Pathology Tests \$-0- 100% MPL

Diagnostic Tests and X-rays \$-0- 100% MPL

Radiation Therapy \$-0- 100% MPL

**Preventative Services**

Cancer Screenings - Covers Prostate, Breast, Uterus, Rectum, Colon (age restrictions apply) \$-0- 100% MPL

Annual Gynecological Exam \$-0- 100% MPL

Pap Smear - One routine Pap Smear every 12 months \$-0- 100% MPL

Well-Baby Care with immunizations \$-0- 100% MPL

Immunizations with Well Baby Care \$-0- 100% MPL

**Other Services**

Allergy Testing and Therapy \$50/\$100 90% MPL

Convalescent Care (up to 730 days) \$-0- 100% MPL

Prosthetic and Orthotic Appliances \$50/\$100 90% MPL

Private Duty Nursing \$50/\$100 90% MPL

Orthopedic Shoes (2 pair annually) \$50/\$100 90% MPL

Hearing Aids (1 every 3 years) \$-0- 100% MPL

Office Visits \$50/\$100 90% MPL

Chemotherapy \$50/\$100 90% MPL

Chiropractic Manipulations (38 visits annually) \$50/\$100 90% MPL

TMJ (\$500 lifetime maximum) \$50/\$100 90% MPL

## **Prescription Drugs (Retail)**

| <b>Copays:</b>                        | <b>(Per Prescription)</b> |
|---------------------------------------|---------------------------|
| Generic                               | \$5.00                    |
| Brand Multi Source                    | \$10.00                   |
| Brand Single Source                   | \$5.00                    |
| Formulary                             | \$5.00                    |
| Brand (when generic is not available) | \$5.00                    |
| Mail Order                            | \$2.00                    |
| Insulin, Needles, Syringes            | \$5.00 or \$10.00         |
| Oral Contraceptives                   | \$5.00 or \$10.00         |
| Genetically Engineered                | \$5.00 or \$10.00         |
| Lifestyle Medications                 | \$5.00 or \$10.00         |
| Injectibles (excluding Insulin)       | \$5.00 or \$10.00         |
| Second Submission                     | Not Covered               |

## **Deductibles and Copayments**

**Deductible (per Benefit Year)** \$50 per member, \$100 per family

### **Copayments**

- \* For Fixed (per service) \$0 office visits
- \* For Percent (% of allowable charge) 10% for general services, mental health care, substance abuse care and private duty nursing

### **Out of Pocket Maximum**

- \* Fixed \$500
- \* Percent, excludes mental health care, substance abuse and private duty nursing copayments Not Applicable

Dollar Maximums: Five Million Dollar (\$5,000,000) lifetime per member for all covered services and as noted above for individual services.

NOTE: Eligibility of medical expenses is determined by BCBSM unless otherwise provided in this document.

## **Riders Included**

CMMXVA - Excludes care for any voluntary abortion procedure

CMMPPPO - Converts existing benefits from a Traditional plan to a Preferred Provider Organization PPO plan.

# INTRODUCTION TO THIS PLAN DESCRIPTION

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## BAY-ARENAC ISD

### TO COVERED EMPLOYEES AND DEPENDENTS:

We are pleased to provide you with this summary plan description (SPD) of your Bay-Arenac ISD Medical Plan. As you read through this booklet, keep in mind that it is intended to be a simple summary of the terms and conditions of benefits covered. Although this booklet describes in general terms the eligibility and benefits provided under this Medical Care Plan, it is not intended to cover every situation that might occur. Additional Comprehensive Major Medical (CMM) benefits in addition to this Plan are provided by Blue Cross and Blue Shield of Michigan (BCBSM), and a description of those benefits can be found in the "Benefits Guide" provided to you by BCBSM.

The purpose of this Medical Plan is to provide additional protection beyond the limits of the BCBSM Comprehensive Major Medical Policy that your employer has purchased. The benefits provided by this Plan are coordinated with benefits paid under the BCBSM CMM Policy. This Plan fills the gap in coverage between the BCBSM CMM Policy and the Medical Care Benefits Plan levels due to larger BCBSM deductibles and copayments. Generally, this Plan reimburses out-of-pocket medical expenses covered under the companion BCBSM CMM Policy up to the deductible limit, and beyond the BCBSM copayment amount up to the stated limits in this Plan. Combined maximum copayment limits are shown in the Benefits Summary found in the front of this booklet. These limits represent the total percentage of covered expenses reimbursed when this Plan and the BCBSM CMM Plan are combined together. This Plan also provides coverage for some expenses that are not covered under the BCBSM CMM Plan.

The following example illustrates this Plan's coverage. An eligible employee is covered for medical surgical care under the employer's BCBSM CMM Plan subject to an annual deductible of \$1,000 and up to a limit of 80% of the Maximum Payment Limit. This Plan will reimburse the employee, or assignment made by the employee, for eligible medical surgical care expenses not covered under the BCBSM Plan, to cover the \$500 out-of-pocket deductible, and to supplement the BCBSM coverage beyond the 80% copayment level to either 90% or 100% of the Maximum Payment Level depending on the type of claim expense.

Under the Bay-Arenac ISD Medical Plan, you will use your Blue Cross Card when receiving benefits. After your claim is processed by BCBSM, they will forward your Explanation Of Benefits Statement to the Benefit Administrator. The Benefit administrator will then re-adjudicate your claim to the benefit levels as outlined in this booklet. This procedure eliminates any double claim handling and submission by you.

Any reference in this booklet to coverage or coverages not shown in this Summary Plan Description (SPD) shall not be applicable.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits are provided for you and your family, and how to obtain those benefits.

## SECTION I.

### IMPORTANT DEFINITIONS AND TERMS

The following terms are used throughout this booklet:

- 1.01 The term "**Actively At Work**" shall mean a Member/Employee must be on the job and physically able (other than absences due to a medical condition or medical treatment) to perform his/her regular full time duties for a regularly scheduled work day. The number of hours which must be worked per week, if any, in order to meet the Actively At Work requirement is shown in the Employer Data Schedule located on page (ii) of this booklet.
- 1.02 The term "**Benefit Administrator**" shall mean the organization the employer has contracted with for benefit and claims administration services. The contact information is in Section 8.01(c) of this document.
- 1.03 The term "**Benefit Year**", or "**Benefit Period**" shall mean the period beginning January 1, and ending on December 31, each year. Any, and all, eligible expenses incurred by a Covered Member during a Benefit Year will be subject to the Plan Maximum benefit.
- 1.04 The term "**Copayment**" shall mean that after a Member has met the deductible amount where required, the Plan will pay a Copayment (as noted in the Schedule of Benefits) of the Maximum Payment Level for the covered service. The remaining percentage (uncovered balance) is your copayment and responsibility.
- 1.05 The term "**Deductible Amount**" shall mean the amount of out-of-pocket expense incurred during each benefit period by the Member to satisfy the individual or family deductible (as noted in the Schedule of Benefits) before payment will begin for covered services subject to deductible. Only services covered under this Plan may be applied toward the deductible amount.
- \* **Carry-Over Provision** - Eligible expenses incurred and applied toward your deductible during the last three months of any calendar year, will be applied toward the following year's deductible.
- 1.06 The term "**Dependent**" shall mean an employee Member's spouse while not divorced or legally separated from the employee Member; and each of the employee Member's unmarried children who can be declared as a dependent on the employee Member's federal tax returns under the Internal Revenue Code of the United States. Eligibility for continuation of coverage for a divorced or legally separated spouse is further provided and defined in Section 3.02 of this document. Dependent eligibility and limiting age of dependents is defined in Section 2.03. An employee Member's children shall include stepchildren, legally adopted children, and any other children receiving coverage pursuant to a Qualified Medical Child Support Order.
- 1.07 The term "**Doctor**", "**Provider**" or "**Legally Qualified Physician**" shall mean a physician licensed to practice medicine and perform surgery. Notwithstanding the foregoing, benefits shall not be denied under the Plan solely because charges are for medical care or services which are not provided by a legally qualified physician, so long as such care or services are provided by a person qualified as a licensed, consulting psychologist and may legally be so provided or provided by a person licensed to practice chiropractic medicine, optometry, or podiatry acting within the scope of his/her license.
- 1.08 The term "**Effective Date**" shall mean this Plan's effective date. An employee's "Effective Date" shall be that date this Plan's benefits became effective for the employee.
- 1.09 The term "**Eligible Charges**" shall mean charges, subject to any limitations or exceptions provided in this Plan actually made to the covered employee for the eligible treatment or services to the extent that such charges are within the Maximum Payment Level (MPL) Fee Schedule established by BCBSM.
- 1.10 The term "**Employee**" shall mean an individual employed by the Employer. An independent contractor is not considered an Employee.

- 1.11 The term "**Employer**" shall mean the Employer listed on the Employer Data Schedule located at the front of this booklet.
- 1.12 The term "**Extended Care Facility**" shall mean an institution or a distinct part of an institution which is primarily engaged in providing, for a fee, room and board and skilled nursing care and related services and which meets each of the following requirements:
- (1) is primarily engaged in providing skilled nursing care and related services for persons convalescing from sickness and injury under twenty-four (24) hour supervision of a legally qualified physician or a registered graduate nurse, (2) has the services of a legally qualified physician available at all times, (3) has such other nursing personnel as may be necessary to provide continuous care of patients, (4) requires each patient be under the care of a legally qualified physician, (5) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals, (6) maintains a daily clinical record for each patient, (7) complies with all licensing and other legal requirements and (8) must be recognized and approved as an Extended Care Facility by Blue Cross Blue Shield of Michigan. However, in no event shall such term include an institution or part thereof which is used primarily as a rest facility, or a facility for the care and treatment of mental diseases or tuberculosis, or for the aged, blind, or the deaf, or for the care of drug addicts or alcoholics, or a facility of custodial or educational care.
- 1.13 The term "**Home Health Agency**" shall mean a public or private agency or organization, or a sub-division thereof, that (1) is primarily engaged in providing skilled nursing and other therapeutic services, (2) has policies established by associated professional personnel, including one or more legally qualified physicians and one or more registered graduate nurses to govern the services provided under the supervision of such a physician or nurse, (3) maintain clinical records on all patients, (4) in cases where state and local law provides for the licensing of agencies or organizations of this nature, the latter is licensed or approved by the state or local law as meeting the standards established for such licensing, and (5) must be recognized and approved as a Home Health Care Agency by Blue Cross Blue Shield of Michigan. In no event will the term "home health agency" include one which is engaged primarily in the care and treatment of mental disease or disorder.
- 1.14 The term "**Hospital**", or "**Facility**" shall mean (1) An institution for the care and treatment of sick and injured persons which is under the supervision of a medical staff of legally qualified physicians and has organized facilities for diagnosis, treatment, major surgery, and twenty-four (24) hour nursing services by registered graduate nurses, or (2) An institution for the treatment of tuberculosis (exclusively) which is under the supervision of a medical staff of legally qualified physicians and has twenty-four hour nursing service by registered graduate nurses, or (3) An institution for the treatment of mental diseases and disorders (exclusively) -- other than an institution the primary function of which is custodial and not therapeutic -- which is under the supervision of a medical staff of legally qualified physicians and has twenty-four (24) hour nursing service by registered graduate nurses. A Hospital must be recognized and approved as a Hospital or Facility by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM non-participating facilities are generally paid at levels lower than the actual charges being made to the patient.
- 1.15 The term "**In-Patient**" shall mean a covered Member who is confined in a hospital as a bed patient for whom a room and board charge is made by the hospital.
- 1.16 The term "**Maximum Payment Level**" or "MPL" shall mean the fee schedule which has been developed between BCBSM and the provider (doctors, hospitals, etc.) community. MPL determines the maximum fees which are to be paid under this Plan.
- 1.17 The term "**Member**", "**Covered Member**" or "**Employee Member**" shall mean an employee who has met the eligibility requirements for coverage under the Plan; "Member" shall also mean, where applicable, a Dependent covered under the Plan by virtue of a relationship to an employee Member.

- 1.18 The term "**Nursing Home**" or "**Convalescent Care Facility**" shall mean a facility for the accommodation of convalescent patients, or other persons who are not acutely ill, which provides skilled nursing care and related medical services and is operated in connection with a hospital or under the general direction of a legally qualified physician.

The term "nursing home" shall not include any facility which is not capable of caring for five (5) or more patients at the same time or which is in existence primarily for the care and treatment of alcoholism, drug addiction, nervous and mental disorders, the aged, the blind, the deaf, or the mentally deficient. Skilled nursing care means nursing care that is under the supervision of a registered graduate professional nurse twenty-four (24) hours each day. A Nursing Home must be a recognized and approved facility by Blue Cross Blue Shield of Michigan (BCBSM).

- 1.19 The term "**Operation**" shall mean a surgical procedure involving one of the following: cutting, suturing, electrocauterization, and removal of stone or foreign body by endoscopic means or injection of sclerosing solution.
- 1.20 The term "**Participating Facility**" shall mean a health care facility in Michigan which participates with BCBSM and accepts their payment as full reimbursement for covered services. They will bill BCBSM directly. You pay only for services not covered under this plan and the BCBSM contract and for required copayments and deductibles.
- 1.21 The term "**Participating Professional**" is a professional who has signed an agreement with BCBSM to accept BCBSM payment as full reimbursement for BCBSM covered services. They will receive direct payment. You will be billed only for services not covered under the BCBSM contract and for required copayments and deductibles.

The term "**Non-Participating Professional**" is a professional who has not signed an agreement with BCBSM, and may or may not accept BCBSM payment as full reimbursement. For services by a non-participating professional, payments are generally made to the Member. The Member may be responsible for an amount greater than the BCBSM/LA Plan payment.

If you are asked to sign a claim form, the professional (doctor) expects to bill you for an amount greater than what BCBSM will allow. Remember you do not have to sign the claim form for BCBSM to make their payment.

- 1.22 The term "**Plan**" shall mean this plan of Medical Care Benefits.

The term "**Other Plan**" shall mean any plan provided by any employer or any other plan required by law that provides medical care benefits or services under:

- (a) Group coverage or any other insured or uninsured arrangement of coverage for which any employer contributes all or part of the cost, and/or makes payroll deductions; or
- (b) Basic automobile reparation (no-fault) coverage, but only to the extent of the benefits required by, or available under the applicable no-fault law, and if such no-fault coverage does not, under its rules, determine its benefits after the benefits of any group health, dental, and/or vision coverage.
- (c) The term "Other Plan" does not include this employer's Blue Cross Blue Shield Comprehensive Major Medical Plan, or individual policies, and/or workers' compensation plans.

Benefits payable under an Other Plan include the benefits that would have been payable if a benefit request had been made for them.

- 1.23 The term "**Plan Administrator**" shall mean this Employer. The Employer has contracted a Benefit Administrator to provide billing, benefit, claims administration, and other administrative services.

- 1.24 The term "**Plan Year**" shall mean that twelve (12) month period over which billing and claims records are maintained and utilized for determining renewal rates.
- 1.25 The term "**Service Requirement**" shall mean the amount of continuous employed time an employee Member must be in active employment in a covered classification with the Employer before the employee can become eligible for coverage under this Plan. The Service Requirement for this group is listed in the Employer Data Schedule located at the front of this document.
- 1.26 The term "**Therapy**" shall mean Physical, Occupational, and Speech Therapy. Such therapy may be provided in the inpatient or outpatient departments of an approved, participating hospital, an approved outpatient physical therapy facility, doctor's office, or an independent physical therapist. Benefits are payable for sixty (60) consecutive days of treatment per condition. Occupational therapy is payable only when provided in conjunction with physical therapy.

The sixty (60) day benefit period begins with the first day of treatment and is per condition, renewed each calendar year or immediately after surgery for the condition treated.

Physical therapy means treatment for a patient whose muscles do not function due to illness or injury. Treatment is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. Treatment is designed to improve muscle strength, joint motion, coordination, and general mobility. To be payable, physical therapy must: Be prescribed by the patient's attending physician; Be given by or under the supervision of a physician or a licensed physical therapist; And, be given for a condition which is capable of significant improvement in a reasonable and generally predictable period of time.

Occupational therapy means treatment consisting of specifically designed therapeutic tasks or activities which: Improve or restore a patient's functional level when there has been a loss in the function of muscles or joints due to illness or injury; And, help the patient learn to apply the newly-restored or improved function to meeting the demands of daily living. To be payable, occupational therapy must be: Prescribed by a patient's attending physician; Provided by or under the supervision of a physician or a licensed occupational therapist; Provided in conjunction with payable physical therapy treatments; And, provided for a condition with the potential for significant improvement in a reasonable and generally predictable period of time.

Speech therapy means active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery. Speech therapy is covered when it is part of a rehabilitation program and is part of the physical therapy benefit. To be payable, speech therapy must be: Referred by the attending physician; Given by a certified speech pathologist; And, provided for a condition expected to be significantly improved in a reasonable period of time.

Examples of covered therapy are: Physical therapy prescribed to restore the use of legs; Physical therapy used in conjunction with a treatment plan to accelerate the healing of an acute injury or illness involving the muscles or joints; And, speech therapy to restore speech following a stroke.

Examples of therapy not covered under this plan: Long-standing, chronic conditions; Developmental conditions or learning disabilities; Congenital or inherited speech abnormalities; And, inpatient hospital admissions principally for speech or language therapy.

- 1.27 Whenever used herein, a masculine noun or pronoun is deemed to include the feminine, and a singular noun or pronoun is deemed to include the plural unless the text involved indicates to the contrary.

## SECTION II.

### ELIGIBILITY FOR COVERAGE

#### 2.01 Initial Employee Eligibility

- (a) **In cases where the Employer pays the full cost of coverage**, an employee shall be eligible for coverage as a Member under the Plan provided he meets all of the following conditions:
- (i) The Plan is in effect for the Employer; and
  - (ii) The employee is included in a class of employees which is eligible for coverage under the Plan; and
  - (iii) The employee is Actively At Work and meets any applicable minimum hours per week requirement; and
  - (iv) The employee has satisfied the applicable Service Requirement.

Coverage will be effective only when all of the above requirements have been met. For example, if an employee meets requirements (i), (ii), and (iv) he will not be a covered Member until he is Actively At Work (meets requirement (iii)).

- (b) **In cases where the employee contributes toward the cost of coverage**, an Employee shall be eligible for coverage as a Member under the Plan provided he has met all of the requirements in paragraph (a) above (subparagraphs i, ii, iii, and iv), and he has completed an enrollment form and authorized his Employer in writing to deduct the required contribution amount from his payroll checks.

**Employees who do not complete a written enrollment and authorization for payroll deduction within thirty-one (31) days after the date of initial eligibility (as defined in paragraph (a) above) may not enroll for coverage in the Plan until the next following Open Enrollment or succeeding Open Enrollments thereafter.**

#### 2.02 Effective Date of Coverage

An Employee's effective date of coverage will be the first day all applicable conditions in Section 2.01 above have been met.

Any eligible medical care services provided a covered Member prior to the Plan's effective date will not be considered a covered benefit under this Plan.

**IMPORTANT NOTE:** Employees must submit a completed enrollment form to the Benefit Administrator within thirty-one (31) days of initial eligibility date for coverage. Prior to the payment of any claims, the Member must have submitted a completed enrollment form to the Benefit Administrator.

#### 2.03 Dependent Eligibility

- (a) If an employee Member is included in a class of employees for which dependent coverage applies, eligible dependents (as defined in Section 1.06) of that employee shall, on the date the employee becomes a Member, become covered Members under the Plan, effective as of the date the employee becomes a covered Member under the Plan provided the dependent is not hospitalized on that date (as described in Subsection 2.02). Should a dependent be hospitalized on the effective date of coverage, coverage will be effective on the date the dependent has been released from the hospital and is able to perform his/her normal duties.

- (b) An employee Member's Dependent Child(ren) can be covered under Family Continuation coverage beyond the end of the calendar year of the Dependent child's nineteenth (19th) birthday, up to the end of the calendar year of their twenty-fifth (25th) birthday, provided **all** of the following conditions are met:
- (i) they are unmarried;
  - (ii) they are dependent upon the Member for more than one-half of their financial support;
  - (iii) they are a member of the Member's household;
  - (iv) they are related to Member by blood, marriage or legal adoption;
  - (v) they are a full-time student for at least five months of the year or had gross income of less than four times the personal exemption amount identified in the IRS gross income test.
- (c) Dependents who are over nineteen (19), and not eligible under Family Continuation, may be eligible for Sponsored Dependent coverage provided they meet **all** the following conditions:
- (i) they are dependent upon the Member for more than one-half of their financial support;
  - (ii) they are a member of the Member's household;
  - (iii) they are related to Member by blood, marriage or legal adoption;
  - (iv) all required additional monthly contributions are made timely on their behalf.
- (d) Dependents, who are the subscriber's child(ren), who are totally and permanently disabled, either physically or mentally. Public Act 275 requires that disabled dependents continue coverage as a regular member (that is, not as a FC or DC rider dependent) if they meet the following requirements.
- (i) they are totally and permanently disabled prior to age 19.
  - (ii) they are incapable of self-sustaining employment.
  - (iii) MEBS is notified of the conditions before the end of the year in which the dependent turns 19 (or age 25 if your plan includes the DC rider)
  - (iv) the disability is certified by a physician.
  - (v) the dependent is unmarried and dependent on the subscriber for primary support and care.

#### 2.04 Change(s) In Coverage/Open Enrollment

The Open Enrollment Period for your group is indicated on the Employer Data Schedule located at the front of this booklet. Employees may enroll and/or make membership changes (such as adding Dependents) during Open Enrollment, or at certain other times subject to the following conditions:

- (a) Family Status Changes, such as addition or deletion of a spouse or Dependents must be made within thirty-one (31) days of the date the change in family status occurred. Otherwise, Family Status changes may be made at the next following Open Enrollment. A change in family status should be reported to the Employer or the Benefit Administrator.
- (b) If a Member's Spouse or Dependent is covered under another Plan, and that Other Plan coverage is subsequently canceled due to layoff, termination, leave of absence, etc., the Member's Spouse, or Dependent may be enrolled immediately in this Plan at the time the Other Plan coverage terminates, provided there is no lapse in coverage between the Other Plan and this Plan and proper application is made within thirty-one (31) days of such event. Otherwise, the Spouse or other Dependent may be enrolled at the next following Open Enrollment.
- (b) Employees who are required to contribute toward the cost of their coverage, and who have not completed enrollment and written authorization for payroll deduction within thirty-one (31) days after they initially become eligible for coverage, may enroll as Members in the next following Open Enrollment or succeeding Open Enrollments thereafter, with coverage to begin effective on the first day of the month of Open Enrollment.

## 2.05 Termination of Membership

Once a Member is initially eligible for coverage under the Plan, his coverage will continue until it is terminated. Termination of coverage will be effective on the first occurring of any of the following dates:

- (a) On the first day of the month for which the Employer's contributions are no longer current; provided that coverage shall be reinstated effective the first of the month for which contributions on the Member's behalf resume provided all other eligibility requirements are met; or,
- (b) On the first day of the month for which the Member's contributions (if applicable) are not current; provided that coverage may be reinstated at the next following Open Enrollment on payment of required contributions thirty (30) days in advance (and provided all other eligibility requirements are met); or,
- (c) On the first day of the month next following the month in which the employee Member ceases to be a member of the class of employees eligible for coverage because of termination of employment or for any other reason; or,
- (d) On the first day of the month next following the date on which the class of employees to which the employee Member belongs is no longer eligible for coverage; or,
- (e) The date on which the Plan terminates.
- (f) Dependent coverage will never extend beyond the termination date of the employee's coverage termination date.

## 2.06 Notice Of Enrollment And Eligibility Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives covered employees/members certain rights regarding enrollment and pre-existing condition limits. Notification of these rights and limits are as follows:

- (a) Insured Plan: This plan is insured by Blue Cross Blue Shield of Michigan (BCBSM) located at: 600 Lafayette East, Detroit Michigan 48226. BCBSM is the insurer and provides claim processing services for a portion of this Plan.
- (c) Plan Administrator: The Plan Administrator is the Employer. The Benefit Administrator provides billing and customer service functions for BCBSM, and claims adjudication and customer service functions for this plan.
- (c) Breast Cancer Benefits: Effective January 1, 1999, group health insurance issuers must cover the following services and procedures given to a Covered Member receiving medical treatment in connection with a mastectomy who elects breast reconstruction:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and medical complications for all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for the above services will be subject to the deductibles that apply to other comparable benefits under this plan.

- (d) Maternity Benefits: Effective January 1, 1998, group health insurance issuers offering group health insurance coverage may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than forty-eight (48) hours following normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.
- (e) Certificates of Coverage: Should a member lose coverage provided under this plan, the Benefit Administrator will, within fourteen days, provide the member with a Certificate of Coverage which will include the following information:
- The Date on which the certificate was issued
  - Name, address and identification number of health plan participant(s)
  - Name of health plan providing the certificate
  - Name of any dependents to whom this certificate applies
  - The waiting/affiliation period under the plan
  - The date that creditable coverage began and the date creditable coverage ended or will end
  - The name, address and telephone number of the plan administrator.

SECTION III.  
GROUP CONTINUATION COVERAGE

**3.01 This Section should be read carefully by the employee Member and all covered Dependent Members:**

Your coverage will end when you and your dependents are no longer eligible to receive benefits through your Employer. However, under the requirement of a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, the Plan makes available to you and your covered dependents the opportunity for a temporary extension of your medical care coverage in certain instances where coverage would otherwise end. To continue this coverage (called Continuation Coverage), you or the affected Dependent will be required to pay the entire applicable Continuation Coverage cost.

**3.02 The following outlines when you and/or your dependents become eligible for Continuation Coverage:**

- (a) If you are a covered employee Member, you have the right to choose Continuation Coverage if your coverage under this Plan ends because of the termination of your employment, a reduction in your hours of employment, layoff, strike, disability, medical leave, or retirement.
- (b) If you are the spouse of a covered employee Member and are covered under the Plan, you have the right to choose Continuation Coverage for yourself if you lose coverage under the Plan for any of the following reasons:
- (i) The death of your spouse who is a covered employee Member; or,
  - (ii) A termination of your spouse's employment, reduction in your spouse's hours of employment, layoff, strike, disability, medical leave of absence or retirement; or,
  - (iii) Divorce or legal separation from your spouse; or
  - (iv) Your spouse becomes entitled to Medicare and his coverage under this Plan terminates.
- (c) If you are a Dependent child of a covered employee Member and are covered under the Plan, you have the right to Continuation Coverage if you lose coverage under the Plan for any of the following reasons:

- (i) The death of a parent who is a covered employee Member; or,
- (ii) The termination of your parent's employment, reduction in your parent's hours of employment with a contributing employer, layoff, strike, disability, medical leave of absence or retirement; or,
- (iii) Your parent's divorce or legal separation; or,
- (iv) Your parent becomes entitled to Medicare and your parent's coverage under the Plan terminates; or,
- (v) You cease to be a "Dependent child" as defined under this Plan.

(d) Newborn or Adopted Child

If you have a newborn child or have a child placed with you for adoption (for whom you have financial responsibilities) while your COBRA continuation coverage is in effect, you may add this child to your coverage by notifying the Fund Office in writing within 30 days after the birth or placement. A child born or placed for adoption while you are on COBRA will have the same COBRA rights as your spouse or dependents who were covered by the plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, their continued coverage depends on the timely and uninterrupted payment of COBRA premiums.

- (e) How Does the Election Take Place? In order to qualify for Continuation Coverage, the employee Member or a covered Dependent has the responsibility to inform their Benefit Office immediately after a divorce, legal separation, or if a child ceases to satisfy the definition of "dependent child" in the Plan. If you do not report one of these events to your Benefit Office within sixty (60) days after loss of coverage due to the event, Continuation Coverage will not be available.

It is the employee/subscriber's responsibility to notify their Benefit Office of family status changes such as employee's death, termination of employment, reduction in hours, layoff, strike, disability, medical leave of absence, retirement or entitlement to Medicare, (This is called a Qualifying Event under COBRA). Failure, on the part of the employee, to notify the Benefit office within 60 days of the Qualifying Event results in loss of COBRA qualification rights. You do not have to show that you are insurable to choose Continuation Coverage (COBRA).

An employee, spouse, or dependent who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of the qualifying events listed above must notify the benefit office of such determination with sixty (60) days after the determination; in addition, the benefit office must be notified within thirty (30) days of a determination that the employee, spouse, or dependent is no longer disabled.

When notice of a qualifying event has been given as described above, notice of the right to elect continuation coverage will be provided to the appropriate parties, notification to a spouse is treated as notification of all other eligible covered members (dependents, living with the spouse).

**If you do not choose Continuation Coverage within the sixty (60) day time limit, your group coverage under the Plan will not be continued.**

If you choose Continuation Coverage, the Plan will give you group coverage which, at the time coverage is being provided, is identical (but not including term life insurance, etc.) to the coverage provided under the Plan to similarly situated covered employee Members and their Dependents.

- (f) What is the Cost? You and/or your dependents must pay the entire cost of Continuation Coverage at group rates. The cost will not exceed 102% of the cost for providing benefits to individuals in the same benefits selection situation as yourself. Specific cost information will be provided to you when you become eligible for Continuation Coverage.

- (g) How Long Does Continuation Coverage Last? Qualifying Beneficiaries will be afforded the opportunity to continue coverage for thirty-six (36) months after the event which caused Continuation Coverage eligibility. However, if loss of group coverage is due to termination of the employee's employment, a reduction in hours, layoff, strike, medical leave of absence, disability or retirement, the Continuation Coverage period is eighteen (18) months for the Employee Member and his/her eligible dependents.

If you, as a spouse or dependent, are receiving Continuation Coverage for the eighteen (18) month period and another qualifying event occurs, e.g., divorce, legal separation, death, loss of dependent status, you are eligible to have your coverage extended to a total of thirty-six (36) months from the date of the first event qualifying you for Continuation Coverage. If the second event is the covered employee becomes entitled to Medicare, and later terminates employment or reduces hours of employment, coverage may be extended to Thirty-six (36) months from the date of entitlement to Medicare. Please be sure to contact your Benefit Office if this occurs.

If an employee, spouse, or dependent is determined to have been disabled under Title II or Title XVI of the Federal Social Security Act at the time of termination of employment or reduction in hours causing a loss of coverage, and if your Benefit Office is notified of such determination before the end of eighteen (18) months of Continuation Coverage, the Continuation Coverage period may be extended to twenty-nine (29) months from the date of initial eligibility or when the individual is determined no longer disabled, if earlier.

- (h) Disability After COBRA Continuation Coverage Begins

If the Social Security Administration determines that you (or a member of your family who is also eligible for COBRA continuation coverage) were totally and permanently disabled on the day you lost eligibility for health coverage under the Plan as an active employee, or within sixty (60) days after that, you or your disabled family member may elect to keep COBRA coverage for twenty-nine (29) months.

You or your disabled family member must notify the Fund Office, in writing, of the Social Security disability determination within sixty (60) days of the date it is issued, and before the end of the initial COBRA coverage period. You or your disabled family member must also notify the Fund Office within thirty (30) days of the date of any final determination by the Social Security Administration that you or your family member are no longer disabled.

As with all COBRA coverage, eligibility for this extension depends on the timely and uninterrupted payment of premiums. If your dependents have COBRA coverage extending past twenty-nine (29) months (i.e., thirty-six (36) months maximum coverage is granted certain qualifying events), then no further extension will be granted because of disability.

Regardless of which continuation period applies, an individual's Continuation Coverage may be cut short for any of the following four reasons:

- (i) This Plan no longer provides group coverage;
- (ii) You do not pay your contributions for Continuation Coverage on time;
- (iii) You or an eligible dependent become covered under another employer sponsored group plan as an employee, dependent or spouse, provided that continuation will not end for an individual for so long as the coverage under another employer sponsored group plan has an exclusion or limitation with respect to any pre-existing condition of that individual which is covered under this Plan; or
- (iv) You or an eligible dependent becomes entitled to Medicare.

3.03 GROUP CONVERSION COVERAGE

When you and/or your dependents are no longer eligible for coverage through your employer, individual (Group Conversion) coverage is available through BCBSM. Your benefits may change and coverage will be limited to your immediate family, but there will be no interruption of coverage, provided you pay the initial bill.

To ensure continuous coverage under Group Continuation, you must make application within thirty (30) days from the date you are no longer eligible for coverage through your group. Contact your employer or your local BCBSM customer service office for additional information on how to apply for Group Conversion Coverage.

Conversion of Coverage: Continuation Coverage is not the same as **Conversion of Coverage**. You are eligible for BCBSM Group conversion when your group plan is terminated. You have thirty-one (31) days from the date of termination to make application directly to BCBSM. Please contact your employer or BCBSM directly for more information.

SECTION IV.

PLAN BENEFITS

**NO MEMBER SHALL HAVE ANY RIGHT OR CLAIM  
TO BENEFITS EXCEPT AS SPECIFIED IN THIS BOOKLET  
AND/OR APPLICABLE INSURANCE POLICIES.**

4.01 General Information: This plan of Medical Benefits is provided on a dually funded basis by your employer.

Your employer has also purchased an underlying insured comprehensive major medical plan of benefits through Blue Cross Blue Shield of Michigan (BCBSM). Your Employer has also retained a benefit administrator, to provide plan and benefit administrative services for benefits which are not included in the BCBSM comprehensive major medical program. Therefore, it is possible from time to time for an employee to receive two Explanation of Benefits Statements (EOB), one from BCBSM and the other from the Benefit Administrator.

BCBSM's unique participating arrangements with health care facilities, doctors, and other professionals limit your out-of-pocket expenses. Participating providers have agreed to accept BCBSM's reasonable charge as full payment for medical services or supplies less any copayments and deductibles for services covered under their program. This Plan will pay benefits consistent with the participating arrangements established by BCBSM.

**Benefits are paid on a Maximum Payment Level basis subject to the allowable percentage and the annual deductible, if applicable. Specific information relating to copays and deductibles can be found in the Coverage Schedule found in this document.**

4.02 IN-HOSPITAL CARE: Participating and Non-Participating Facilities, for in- and outpatient services.

TYPE OF SERVICE

DESCRIPTION OF BENEFIT

|                             |  |
|-----------------------------|--|
| Inpatient Hospital Days     | Pays for general conditions (semi-private room) and a private room if medically necessary. |
| Intensive Care Units        | Burn, cardiac and other special care units.  |
| Treatment Rooms             | Operating, recovery, delivery and other surgical treatment rooms.                          |
| Drugs, Dressings, and Casts | Biologicals, solutions, gauze, cotton, fabrics and plaster.                                |

|                             |   |
|-----------------------------|---|
| Prosthetic Appliances       | Artificial devices which replace all or part of a body part, or the functions of a body part which is permanently implanted within the body, such as heart valves and hip joints. |
| Use of Hospital Equipment   | Wheelchairs, kidney machines, incubators, oxygen tents and other equipment.   |
| Physical Therapy Treatments | Physical, speech and occupational therapy medically necessary for the treatment of a condition for which a member is hospitalized.  |
| Maternity Care              | Delivery including pre & post natal care of the mother and routine newborn nursery care during the mother's stay.   |
| Dental Treatment            | Multiple extractions or removal of unerupted teeth when a concurrent hazardous medical condition exists.  |
| Laboratory and Pathology    | For the examination of blood, tissue, urine and other body fluids.  |

FOR SERVICES RECEIVED IN NON-PARTICIPATING BCBSM FACILITIES, THE PLAN WILL PAY AN AMOUNT USUALLY LESS THAN THE FACILITY CHARGES FOR SUCH SERVICES. Benefits include up to \$70 a day in acute, general care hospitals (up to \$15 in other hospitals) and up to \$25 per condition for covered outpatient services. Check master agreement or individual employment contracts for benefit levels.

4.03 MEDICAL-SURGICAL CARE: Participating and Non-participating Professionals - Health care professionals include physicians, pharmacists, laboratories and certain other professional practitioners.

| <u>TYPE OF SERVICE</u>        | <u>DESCRIPTION OF BENEFIT</u>   |
|-------------------------------|---|
| Surgery                       | Diagnosis and treatment of disease, fractures, dislocations, cosmetic surgery for the correction of certain deformities, and voluntary sterilizations (including termination of pregnancies). |
| Technical Surgical Assistance | Physician assistance to the operating surgeon in a major surgical procedure if intern or house officer is not available.  |
| Anesthesia                    | Administration of drugs or gases by an anesthetist.   |
| Dental Treatment              | Multiple extractions or removal of unerupted teeth as an inpatient and when a concurrent hazardous medical condition exists.  |
| Inpatient Medical Care Days   | Care by a physician for general medical and limited amounts for nervous/mental health conditions.   |
| Inpatient Consultations       | Inpatient services of a consulting physician in the diagnosis and treatment of a condition.   |
| Second Surgical Opinions      | Outpatient visits to physician's to confirm elective surgery or the patient's capacity to undergo surgery.  |
| Emergency Treatment           | Hospital and physician charges for the initial examination and treatment of accidental injuries and life threatening medical emergencies.   |
| Non-Emergency Treatment       | Benefits for services in an emergency room for the treatment of non-medical emergencies are payable subject to deductible(s) and co-payments(s).  |
| Laboratory and Pathology      | For the examination of blood, tissue, urine and other body fluids.  |
| Electromodality Studies       | Electrocardiograms (EKG), Electroencephalograms(EEG) and Electromyelograms (EMG).   |
| Radiology                     | Diagnostic and therapeutic x-rays, radioactive isotopes, cobalt, ultrasound and CAT scans of the head and body.   |

Routine Pap Smear Up to the allowed MPL. For Laboratory and pathology services only, payable once in a 12 month period.

Cosmetic Surgery To correct congenital anomalies, conditions resulting from accidental injuries or traumatic scars and for the correction of deformities resulting from certain surgeries including breast reconstructive surgery following mastectomies.

Mammograms Up to the allowed MPL for members over age 34, one during the period between ages 35 to 40, and then one annually thereafter.

4.04 OTHER HEALTH CARE SERVICES: Billed By Participating Physicians, Hospitals And Other Health Care Professionals.

TYPE OF SERVICE

DESCRIPTION OF BENEFIT

Special Therapy Programs Home hemophilia, hyperalimentation products, home health care and home and outpatient hemodialysis, when arranged by a physician.

Professional Ambulance Services Transportation to a hospital, or from a hospital to another treatment center, such as another hospital or convalescent center.

Private Duty Nursing When the patient's condition requires continuous services of a professional nurse on a one-to-one basis. Must be prescribed by a physician and rendered by a registered or licensed practical nurse.

4.05 MISCELLANEOUS HEALTH CARE SERVICES: Billed By Participating Physicians, Hospitals, And Other Health Care Professionals.

TYPE OF SERVICE

DESCRIPTION OF BENEFIT

Doctor Office Visits, Outpatient Covers medical care visits and therapeutic injections in a physician's office, patient's home or hospital outpatient department for an examination, diagnosis and treatment of any disease or illness (except mental).

Chemotherapy Chemotherapy through veins, arteries and closed body cavities, administration, physician supervision and drug costs for the treatment of malignant diseases; outpatient department and physician's office. Includes three follow-up visits within 21 days of covered chemotherapy treatment.

Chiropractic Services Chiropractic care is limited to twenty (20) visits within a 90 day period for acute conditions, and not more than two (2) visits per month for chronic conditions. Benefits are also payable for the initial consultation per condition (diagnosis) which includes the initial examination, history, setting up files, etc., but separate from the spinal manipulation.

Dental Services Dental services and appliances for treatment of accidental injuries.

Oxygen and Other Therapeutic Gases When the patient's condition warrants use in the home and prescribed by a physician.

Medical Supplies Home medical supplies for certain conditions when prescribed by a physician such as ostomy supplies.

Maternity Care Pre- and Post-natal care visits.

Well Baby Care (By Physician) Up to allowed MPL, on an inpatient basis, plus four outpatient visits during the first twelve months. Immunizations are included with well baby care at 90%.

Allergy Testing and Therapy Includes scratch and puncture tests, ultrasound and radiotherapy treatments and injections.

Physical and Speech Therapy Treatment by a doctor, a registered physical or speech therapist, hospital outpatient or participating freestanding physical therapy facilities.

|                                    |  |
|------------------------------------|--|
| Prosthetic and Orthotic Appliances | External appliances prescribed by a physician such as artificial limbs, external breast prostheses, and braces.  |
| Hearing Aids                       | Up to the allowable MPL not to exceed one in any three year period. Must be a BCBSM Par Hearing Care Provider.   |
| Durable Medical Equipment          | Rental or purchase of physician-prescribed equipment that is reusable and appropriate for home use such as crutches, I.V. stands, walkers, wheelchairs, and hospital beds.   |
| Blood                              | Whole blood, blood derivatives, blood plasma, supplies and their administration.   |
| Visiting Nurse Services            | When minimal nursing care and/or professional supervision is prescribed by a physician and rendered in the home by a non-profit visiting nurse service.  |
| Nursing Home/Convalescent Care     | Up to the MPL amount per day not to exceed the allowed number of days in an approved skilled nursing facility.   |
| Diabetes Coverage                  | Effective March 28, 2001, Michigan laws took effect requiring benefit coverage for certain diabetic prescription drugs, supplies, equipment and self-management training. These benefits are subject to copayments and deductibles. Services must be medically necessary and prescribed by an M.D. or D.O. Benefits are as follows: <ul style="list-style-type: none"> <li>- Syringes and needles for Insulin purposes only</li> <li>- Test strips for glucose monitors</li> <li>- Visual reading and urine testing strips</li> <li>- Lancets</li> <li>- Spring-powered lancet devices</li> <li>- Insulin pumps and medical supplies required for the use of the pump</li> <li>- Blood glucose monitors</li> </ul> |

4.06 **MENTAL HEALTH CARE:** Benefits are paid according to the percentages as identified in the Schedule of Benefits (page iii and iv), and subject to the Maximum Payment Level and annual deductible, if applicable. Includes care in a physician's office and/or outpatient mental health facility for such services as psychological testing, group therapy sessions and individual and family counseling.

**Out of Pocket Maximum:** The Out of Pocket Maximum does not apply to deductible and copayments for mental/nervous, substance abuse, private duty nursing and any non-covered services.

TYPE OF SERVICE

DESCRIPTION OF BENEFIT

|                               |  |
|-------------------------------|--|
| Mental & Nervous (Inpatient)  | Up to 45 days for mental/nervous health conditions. Days renew following 60 consecutive days for the date of last discharge.   |
| Mental & Nervous (Outpatient) | Up to 50 visits per member per calendar year. Includes care in a physician's office and/or outpatient mental health facility for such services as psychological testing, individual and group therapy sessions and family counseling. Services must be performed by a fully licensed psychologist or psychiatrist. |
| Substance Abuse (Inpatient)   | Up to 45 days, but not less than the minimum care benefit provided by law, of physician medical care for acute care detoxification and hospital residential intermediate care in approved programs. Days renew following 60 consecutive days from date of last discharge.  |
| Substance Abuse (Outpatient)  | Up to 35 visits per year, but not less than the minimum benefit provided by law, in approved hospital and non-hospital based outpatient programs.  |

**Out of State Inpatient Care:** All out of state inpatient care requires Michigan Blue Cross pre-certification prior to admittance to a facility. For additional information regarding this provision, contact the Benefit Administrator.

4.07 **LIFE INSURANCE BENEFITS:** The Bay-Arenac Program includes \$10,000 Term Life Insurance, \$10,000 Accidental Death and Dismemberment and a \$5,000 Seatbelt Rider as a part of the Medical Program. Additionally, Supplemental Term Life Insurance and Dependent Term Life are available on a payroll deduction basis.

4.08 **OTHER BENEFITS:** Benefits are paid according to the percentages as identified in the Schedule of Benefits (page iv), and subject to the Maximum Payment Level and annual deductible, if applicable.

**Home Health Care** Benefits covered when patient is referred to and accepted by a participating home health care agency which will provide the medically necessary services. Services must be prescribed by the attending physician who certifies that the patient is confined to the home due to illness.

**Hospice Care** A hospice is an agency or facility that is primarily involved in providing care to terminally ill individuals. Hospice care is designed to replace inpatient hospital care. Services may be provided in hospice facilities or in the home. All hospice services must be arranged through a BCBSM-approved hospice provider.

Hospice benefits replace the benefits available under your current coverage. However, any services you receive for conditions unrelated to the terminally illness are still covered by your current benefits.

When you are accepted into an approved hospice program, you are covered up to allowable dollar maximum of two 90-days periods and one 30-day period of care.

Coverage includes:

- Physician Care
- Nursing Care
- Home Health Aide Services
- Medical Social Services
- Supplies and Drugs
- Physician Therapy and Counseling
- Durable Medical Equipment
- Bereavement Counseling

Check with the Benefit Administrator for information about the current dollar amount allowed for hospice care.

**Human Organ Transplants** The following types of human organ transplants are covered when received at a participating facility, or where noted, in a BCBSM-approved transplant facility.

**Organ and Tissue Transplants:** Benefits are payable for services and expenses for transplantation of organs and tissues when performed in a participating facility. Benefits include evaluation and surgical removal of donated part from a living or non-living donor including skin, cornea, and kidney. These transplants are subject to CMM coverage limitations and exclusions.

**Bone Marrow Transplants:** Benefit for bone marrow transplants are payable only when the bone marrow of another person is transplanted into the patient to treat the following conditions:

- Aplastic anemia
- Severe Combined Immune Deficiency disease (SCID)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's Lymphoma (intermediate high grade)
- Hurler's Syndrome
- Acute Non-Lymphocytic Leukemia
- Acute Lymphocytic Leukemia
- Chronic Myeloid Leukemia
- Wiskott-Aldrich Syndrome
- Osteoporosis
- Beta Thalassemia, major
- Hodgkin's Disease (stage III or IV)
- Myelodysplastic Syndromes

Bone marrow transplants are payable when the donor is an immediate relative and has either the same or five of the six important genetic markers as the patient. When only five of the six markers match, the mixed lymphocyte culture (MLC) must be negative. **Donors outside of the immediate family must have the same six important genetic markers as the patient.**

**Note:** Genetic markers are specific chemical groupings of white blood cells (human leukocyte antigens [HLA]) used to detect the constitutional similarity of one person to another. The **important** markers are HLA-A, HLA-B, and HLA-DR from both parents.

Payable benefits include:

- Blood tests on relatives for evaluation as donors if the tests are not covered by the donor's plan.
- Harvesting of marrow if not covered by the donor's plan, and if the donor meets all of the genetic marker requirements
- Search of the National Donor Marrow Program registry for a donor, and harvesting and transportation of marrow when the donor meets all of the genetic marker requirements (The Registry's bill must be submitted to BCBSM by the Bone Marrow Transplant Center.)

**Human Organ Transplants  
Continued**

Your coverage also includes transplants of the patient's own bone marrow and/or transplanting the patient's own peripheral blood stem cells when used to rescue a patient after receiving high doses of chemotherapy. Only the following conditions are covered:

- Acute Non-Lymphocytic Leukemia
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's Lymphoma (intermediate or high grade)
- Acute Lymphocytic Leukemia
- Hodgkin's disease (stage III or IV)
- Germ cell tumors of ovary, testes, mediastinum, and retroperitoneum

Your coverage **does not** pay for:

- Bone marrow transplants if the donor does not meet all of the genetic marker requirements
- Bone marrow transplants or high dose chemotherapy for conditions other than those listed
- Purging or positive stem cell selection of the bone marrow or peripheral stem cell collection.
- Any facility or physician services related to any of the above exclusions.

**Specified Human Organ Transplants:** Your coverage provides payment of 100% of the approved amount for hospital and physician services for specified human organ transplants. You are not required to pay any deductible or copayments.

Human organ transplants are covered when performed at a BCBSM-approved facility. Your physician must obtain authorization from BCBSM prior to surgery. The eligible benefit period begins five days before surgery and ends one year later. Coverage is for transplanting the following human organs:

- Liver
- Lung
- Heart-Lung
- Heart
- Pancreas

Benefits include the following services:

- Medically necessary related services such as office visits, visiting nurses, home health care, cardiac rehabilitation, and durable medical equipment.
- Surgical storage and transportation costs of donated organs up to \$10,000 (subject to the lifetime maximum)
- Anti-rejection drugs during the transplant benefit period. After the benefit period, drugs are covered up to a maximum of \$10,000 per year, subject to the lifetime maximum.
- Transportation to and from the transplant facility, meals and lodging up to \$10,000 for the patient and one companion (two, if the patient is a minor). This is subject to the lifetime maximum.

Specified human transplant needed as a result of a pre-existing conditioner not payable unless they are provided after the member's coverage has been in effect during the nine months prior to the transplant. This waiting period does apply if the member was continuously covered under a previous BCBSM contract that included specified human organ transplant benefits.

4.09 PRESCRIPTION DRUGS: The Prescription Drug Program is provided through a professional Prescription Drug Manager. The Prescription Program protects against unpredictable costs of health sustaining drugs and at the same time is designed to save money through the use of generic equivalent drugs. Generic equivalents are simply drugs that can be produced by more than one manufacturer and distributed under more than one name. However, it is important to understand that the Food and Drug Administration requires these drugs to meet the same standards as brand name drugs. Your pharmacist has a complete listing of the generic equivalent drugs covered under this program.

With the exception of insulin, if there is a generic equivalent to a brand name drug, the pharmacist will automatically dispense the generic equivalent. Brand name drugs will be dispensed only if the doctor has indicated "Dispense as Written" (DAW) on the prescription or if a member asks for the brand name drug. Brand Name Drugs may be subject to a higher copay than a generic brand. If you ask for the brand name drug, you may have to pay an amount greater than the generic copayment.

Prescription drugs which are billed by Participating Pharmacists:

| <u>TYPE OF SERVICE</u>          | <u>DESCRIPTION OF BENEFIT</u>   |
|---------------------------------|---|
| Prescription Drugs              | Injectable insulin and federal legend drugs dispensed up to a 90-day supply or, for certain maintenance drugs, 100 unit doses, whichever is greater.  |
| Copay                           | This Plan will pay 100% after a copay (per employee agreement or contract) has been paid by the Member per prescription.  |
| "DAW"<br>(Dispensed As Written) | This is applicable when a patient chooses a multi-source brand medication where a FDA approved generic form is available, and the prescribing physician did not indicate Dispensed As Written, the patient is responsible for the difference in cost between the brand form dispensed and the generic equivalent, in addition to the copayment (up to, but not to exceed, the full cost of the medication). |

**BENEFITS AT NON-PARTICIPATING PHARMACIES:** When a member goes to a non-participating pharmacy in Michigan, they must pay the full charge for each prescription or refill. The member will be reimbursed 75% of the approved amount minus the copay per prescription. If the member requests a brand name drug instead of the generic equivalent, they will be reimbursed 75% of the maximum allowable cost for the generic equivalent drug minus your copayment.

Prescription Drugs Covered:

- (i) Drugs which, under Federal Law, are required to bear the legend: "CAUTION: Federal Law prohibits dispensing without prescription."
- (ii) A compound medication of which at least one ingredient is a Federal Legend Drug.
- (iii) Other drugs which, under the applicable State Law, may only be dispensed upon prescription by a physician.
- (iv) Injectable insulin, including needles and syringes.
- (v) Federal Legend Oral Contraceptives and Devices.

## SECTION V

### EXCLUSIONS AND LIMITATIONS

5.01 EXCLUSIONS : In addition to applicable limitations appearing elsewhere in this booklet, the following services are excluded under this Plan:

- Services paid by Medicare as the primary benefit plan;
- Services covered in full by other BCBSM contracts or any other service plan;
- Services provided before the effective date of this Plan;
- Services provided after termination of this Plan;
- Services which are not medically necessary;
- Treatment of mental disorders extending beyond period necessary for diagnostic evaluation of mental retardation or beyond period where favorable modification cannot result;
- Health tests unrelated to previously diagnosed conditions except as specifically provided;
- Charges determined to be unreasonable;
- Research or experimental services and treatment;
- Weight reduction by diet control;
- Services that are not health care services (personal and convenience items, completion of forms, cost of transportation except ambulance service);
- Services and supplies not prescribed by a physician;
- Services by persons not qualified or licensed;
- Services provided by employer facilities;
- Services for occupational injuries or disease;
- Services available without cost, through the government or under a government health plan;
- Services resulting from military action or war, declared or undeclared;
- Hospitalization principally for observation or diagnostic evaluation, physical therapy, x-ray or laboratory tests;
- Routine physical, pre-marital or pre-employment examinations, and other related services;
- A service rendered by a doctor who ordinarily resides in the same household with the employed member or who is a member of the employed member's immediate family (i.e. children or spouse) where charges are not normally made;
- Artificial insemination, in-vitro fertilization, or any other fertilization procedure to ensure pregnancy.
- Voluntary abortions

In addition, the prescription drug program does not cover:

- Drugs costing less than the copayment requirement;
- Drugs requiring a prescription by state law, but not federal;
- Any covered drug which is consumed at the time or place of the prescription order;
- Smoking cessation medications;
- Administration of drugs;
- More than a 90-day supply, except for specified maintenance drugs which are covered in 100-unit doses;
- Refills not authorized by a physician;
- Refills dispensed after one year from the date of the original order;
- Medications covered by any Workers' Compensation Law or available without charge from any government program;
- Medications provided to you as a hospital inpatient or outpatient and covered under the basic contract.

5.02 LIMITATIONS: In addition to applicable exclusions appearing elsewhere in this document, the following services are limited under this Plan:

- Professional services for outpatient treatment of substance abuse are considered outpatient treatment of mental disorders, and are subject to the outpatient visit limitation;

- In-hospital dental treatment and other related professional services are covered only for multiple extractions, removal of one or more unerupted teeth, alveoplasty or gingivectomy, when a concurrent hazardous medical condition exists;
- Cosmetic surgery benefits are limited to correction of congenital anomalies, conditions resulting from accidental injuries or traumatic scars and for the correction of deformities resulting from cancer surgery and mastectomies;
- Eyeglasses and related services unless member lacks natural lenses;
- Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than direct surgery on the jaw joint, arthrocentesis (injections) or x-rays.

## SECTION VI.

### COORDINATION OF BENEFITS

#### 6.01 Benefit Determination

In computing the benefits payable under this Plan, the benefits from Other Plan will be taken into account. The term "Other Plan" is defined in the Section Important Terms. This Coordination of Benefits may require a reduction in benefits under this Plan, so that the combined benefits of this Plan and the Other Plan will not be more than the allowable usual, customary, and reasonable charge.

#### 6.02 Computation of Benefits

This Plan will always either pay its regular benefits in full, or it will pay a reduced amount which, when added to the benefits payable and the cash value of any services provided by the Other Plan(s), will equal 100% of the allowable expenses incurred by the covered Member for whom a claim is being filed.

#### 6.03 Order of Benefit Determination

If a covered Member is eligible to receive benefits under this Plan, and is eligible at the same time to receive similar benefits under any Other Plan, payment of benefits will be made according to the following order:

- (a) Benefits of any Other Plan, which does not contain a provision for coordination with other plans, are determined prior to determination of any benefits of this Plan.
- (b) Primary liability rests with the plan under which the covered Member is eligible as a covered **employee**. Secondary liability rests with the plan under which the covered Member is eligible as a **dependent**. In situations where the covered Member is the employee and also is covered as an employee by an Other Plan (as defined in Section 1.22), the Order of Benefit Determination will be those rules as outlined in subsections 6.03(d) and 6.03(e).
- (c) When neither (a), nor (b) is determinative, primary coverage for a dependent child is with the plan covering the parent whose birthday occurs earlier in the calendar year. If both parents have the same birthday, the benefits of the plan which has the covered Member claiming benefits longer are determined before those of the plan which covered the covered Member for a shorter period of time. If the Other Plan does not have this rule coordination is determined under the rules of the Other Plan.

However, when the parents of a dependent child are legally separated or divorced, the following order of benefit determination applies: the Plan covering the child as a dependent of a parent who has been given financial responsibility for medical, dental, or other health care expenses of the child under a court order of decree is primary. Otherwise, the plan covering the custodial parent

will be primary; where the custodial parent has remarried, coverage of the custodial parent will be primary, followed by the plan covering the child as a dependent of the custodial parent's spouse, followed by the plan of the non-custodial parent.

- (d) The Benefits of a plan which covers a Covered Member as an employee who is neither laid off nor retired (or as that employed Member's Dependent) are determined before those of a plan which covers that Covered Member as a laid off or retired employed Member (or as that Member's Dependent). If the Other Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (e) If the above rules do not establish an order of benefit determination, primary liability rests with the plan, which has covered the Covered Member or Dependent continuously for the longer period of time.
- (f) Where a Covered Member is subject to certain cost containment provisions under the primary plan, any cost containment sanction(s) imposed by the primary plan will not be payable as a benefit, or a secondary balance, by any of the other secondary plan(s).

6.04 Standard Coordination of Benefits: Should a dependent spouse or child who is also covered as an employee, and is also considered a dependent under the Plan, the Coordination of Benefits provisions is **Standard**. This Plan has **Standard** Coordination of Benefits.

## SECTION VII.

### CLAIM PROCEDURE AND GENERAL PROVISIONS REGARDING BENEFITS

#### **NO MEMBER SHALL HAVE ANY RIGHT OR CLAIM TO BENEFITS EXCEPT AS SPECIFIED IN THIS BOOKLET AND/OR APPLICABLE INSURANCE POLICIES.**

#### 7.01 Filing a Claim

- (a) If you have a claim from a non-participating provider, contact your Employer or the Benefit Administrator (the Benefit Administrator is listed in Section 8.01(c) to obtain a claim form. A claim form which has been approved by the Health Insurance Association of America (HIAA) is acceptable to the Benefit Administrator. BCBSM will only accept claims on their approved Subscriber Application for Payment (SAP) form available through your Employer, BCBSM, or the Benefit Administrator. Written proof of loss must be furnished to BCBSM and/or the Benefit Administrator on the approved claim form within two (2) years after the date the covered expense is incurred.

Benefits will not be paid until BCBSM and/or the Benefit Administrator receives written documentation of the occurrence, nature and extent of the expense for which the claim is filed. Failure to furnish such documentation within the required time shall not invalidate nor reduce any claim if it was not reasonably possible to give documentation within such time, provided such documentation is furnished as soon after as reasonably possible.

**Important note regarding late claims:** The Plan will not honor, and no payment will be made for a claim which has not been received by the Plan within two (2) years following the date of service.

- (b) The Benefit Administrator may examine the Member whose sickness or injury is the basis of the claim when and so often as it may deem necessary during pendency of the claim.

- (c) No action at law or in equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after written proof of the loss upon which claim is based has been furnished above. No such action shall be brought more than three (3) years after the expiration of the time within proof of such loss is required.
- (d) An assignment of benefits, authorizing the Administrator to make payment directly to the Provider, shall be signed by the employee Member. All payments will then be made directly to the provider, unless the covered Member then notifies the Administrator in writing to make payment directly to that covered Member.

### Care Outside of Michigan

If an eligible employee or covered dependent receives treatment outside of Michigan, by a Blue Cross or Blue Shield Participating Provider, the employee needs to only show his/her BCBSM Identification Card. The participating provider will send the bill directly to BCBS.

If an eligible employee or covered dependent receives treatment outside of Michigan from a non-participating provider, the employee or dependent needs to secure an itemized statement or receipt for services provided. This statement must be submitted to Michigan BCBSM along with a Subscriber Application for Payment Form (SAP) available from the employer or Benefit Administrator.

7.02 Appeal of Denied Claims Should a Member disagree with a decision of the Plan regarding benefits, the Member may file an Appeal of Denied Claims. To file an Appeal of Denied Claims, a Member or his authorized representative should:

- (a) Write to the Plan listing the reasons for the appeal, and
- (b) Provide any and all facts upon which are relied on for the appeal, and
- (c) Mail the Appeal of Denied Claims to the Benefit Administrator listed in Section 8.01C.

The Member must mail the appeal within sixty (60) days from the date he received notice of the Plan's decision that is disputed. In preparing his appeal, he may examine or copy documents, as described in this booklet.

The Plan representatives will review the appeal promptly and advise the Member of their decision in writing, setting out specific reasons for the decision and specific references to Plan provisions on which it is based. The written decision will be issued within sixty (60) days after the appeal is received, unless special circumstances require more time for processing the appeal, in which case the Member will be so informed. In no event will the decision be issued later than one hundred-twenty (120) days after receipt of the appeal.

7.03 Workers' Compensation This Plan does not take the place of or affect any requirement for coverage by Workers' Compensation Insurance.

7.04 Right of Recovery If an overpayment is made due to any reason, including but not limited to payment under any workers' disability or occupational disease act or law, clerical error or misstatement of age, the Plan shall have the right to recover such overpayment from the covered Member, or to deduct such amount of overpayment from future benefits. This provision shall be in addition to, and not in lieu of, any other remedy available to the Plan at law or in equity.

7.05 Subrogation If a Member incurs expenses on account of bodily injury or sickness, caused by negligence or wrong of a third party, and benefits are payable under this Plan, the Member will receive the benefits, provided that, if there is recovery by the Member or any dependents or a personal representative from the third party, or his/her personal representative, whether by judgment, settlement or otherwise, on account of such bodily injury or sickness, the Member shall reimburse the Plan to the extent of the total amount of such benefits paid under this Plan, but not in an amount in excess of the proceeds of any such recovery

after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

- 7.06 Release of Information Each Member covered under this Plan hereby authorizes physicians, hospitals, and other providers of service to furnish the Plan's designee, upon request, information relating to services which the covered Member is or may be entitled to coverage for under this Plan.

Physicians, hospitals and other providers of services are hereby authorized to permit the Benefit Administrator to examine their records with respect to such services. All information related to treatment of the Member will remain confidential and shall be used solely for the purpose of determining rights and liabilities arising under this Plan.

- 7.07 Assignment Limitations Coverage is not assignable unless the Employer Data Schedule indicates that it is "Assignable". No responsibility for the validity or sufficiency of any assignment is assumed by the Employer. The Administrator shall not be considered to have knowledge of any assignment unless the original or a duplicate is filed with the Benefit Administrator through the Employer.

- 7.08 Qualified Medical Child Support Orders Under federal law, the Plan must recognize a qualified medical child support order (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order that recognizes the right of an alternate recipient (child) to receive benefits under the Plan. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to children [of] eligible Employee members. A QMCSO is usually issued in a divorce where an Employee member or his former spouse is ordered by the court to continue to provide medical support for their child or children. When the Plan Administrator receives an order that may include a QMCSO, it will review the order and make a determination as to the order's qualified status. The Plan Administrator of the determination will then notify the eligible Employee and possible alternate recipient. Payment of benefits made pursuant to a QMCSO may be made to the alternate recipient's custodial parent or legal guardian.

- 7.09 Not a Contract of Employment Nothing contained in the Plan or this summary plan description shall be construed as a contract of employment between the Employer and any person, nor does the Plan give any person the right to be retained as an employee.

## SECTION VIII.

### PLAN ADMINISTRATION AND GENERAL INFORMATION

- 8.01 General Information The Employer has established this Plan exclusively to provide medical care and other related benefits to its eligible employees and their families in conjunction with an underlying BCBSM CMM plan. The Plan is established, funded, maintained, and sponsored by the Employer. The Employer has contracted with the benefit administrator to provide billing, benefit, and claims administration services.

The following is important information concerning this Plan:

- (a) **Name of Plan:**

BAY-ARENAC ISD - MEDICAL CARE BENEFITS PLAN

- (b) **Plan Administrator and Fiduciary:**

Bay-Arenac ISD is the Plan Administrator and Fiduciary of this Medical Care Benefits Plan.

- (c) **Benefit Administrator:**

The Employer has contracted with Michigan Employee Benefit Services, Incorporated (MEBS), for

benefit and claims administration services. Any questions about benefits may be directed to MEBS at the following location:

Michigan Employee Benefit Services, Inc. (MEBS)  
25 Jefferson Ave.  
Jefferson Place  
Grand Rapids, Michigan 49503  
www.mebs.com

Telephone number(s): (800) 968-6327  
(616) 458-6327  
www.custserv@mebs.com

The Benefit Administrator:

- (i) Does not guarantee or warrant this is an insured plan. The Employer assumes all responsibilities for insuring benefits on behalf of Members covered by the plan(s).
- (ii) Does not insure, reinsure, or fund this benefit plan. Should the Plan Sponsor elect not to reinsure this plan, and ultimately not pay (fund) benefit expenses that are eligible for payment under the plan for any reason, the Members covered by the plan may be liable for those expenses.
- (iii) Merely processes claims and does not insure the eligible expenses of the Plan. The Administrator does not guarantee Members covered under the plan that eligible expenses will be paid.
- (iii) Will promptly process complete and proper claims submissions for benefits made by Members covered by the plan. In the event there are delays in processing claims, the Members covered by this plan shall have no greater rights to interest or other remedies against the Benefit Administrator than as otherwise afforded by law.

(d) **Federal Identification Number:**

The Plan has been assigned the following employer identification number by the Internal Revenue Service: 38-1715580

(e) **Plan Year:**

The Plan's fiscal records are maintained on a plan year basis from July First (1<sup>st</sup>) through June Thirtieth (30<sup>th</sup>).

(f) **Agent for Service of Legal Process:**

Superintendent  
Bay-Arenac ISD  
4228 Two Mile Road  
Bay City, MI 48706  
(989) 686-4410

8.02 Source of Contribution This Plan is funded by the Employer and is established and maintained for the sole purpose of providing benefits to eligible Member Employees and their covered Dependents. Benefits are provided through insurance policies, and on a dually funded basis by the Employer. Should the Plan ultimately not pay benefit expenses which are eligible for payment under this Plan for any reason, the Members covered by this plan may be liable for those expenses.

8.03 Legal Action No legal action shall be made against the Plan prior to the expiration of sixty (60) days of receipt of claim. No such action shall be brought after the expiration of three years of receipt of claim.

8.04 Questions Regarding this Plan The benefit administration of this Plan is handled by the staff of the Benefit Administrator. Only employees of the Benefit Administrator are qualified to answer questions regarding benefits, eligibility, and other terms and conditions of the Plan. Any questions about benefits may be directed to them.

Should a Member desire to inspect or receive copies of additional documents relating to this Plan, contact the Benefit Administrator at the address or phone number shown in Section 8.01C. The Member will be charged a reasonable fee to cover the cost of reproducing any materials he wishes to receive.

8.05 Member Responsibilities The following actions by Members will facilitate prompt payment of eligible claims:

- (a) When you write to the Benefit Administrator Office, please be sure to provide your name and Social Security number in your letter. If you call, please be sure to have your Social Security number handy.
- (b) Notify your Employer, and the Benefit Administrator Office within thirty (30) days after the date you gain or lose a Dependent (spouse or child) for any reason, for example, due to divorce, separation, death, or age.
- (c) If you or one of your Dependents becomes eligible for Social Security benefits and/or Medicare coverage, you must send a copy of the Social Security Award Letter and/or Medicare Card to your employer and the Benefit Administrator Office immediately.

**Notify the Benefit Administrator immediately if you change your home address.**

8.06 Interpretation Of Plan: The Plan Administrator (or in some cases the Underwriter, BCBSM) has sole authority to interpret and apply the provisions of this Plan, and to determine eligibility for coverage and benefits. The decisions of the Plan Administrator and/or Underwriter are final and binding on all parties.

8.07 Amendment or Termination of the Plan The Employer may amend the Plan at any time. Although the Employer anticipates that the Plan will remain in effect, it reserves the right to terminate this Plan at any time. Any funds remaining in the Plan at termination will be distributed for the benefit of Members in a manner determined by the Employer.

ATTACHMENT "A"

SUMMARY OF BLUE CROSS/BLUE SHIELD BENEFITS

COMPREHENSIVE MAJOR MEDICAL CARE BENEFITS PLAN

**HOSPITAL/SURGICAL/MISCELLANEOUS BENEFITS**

I. MAXIMUM BENEFITS:

| BENEFIT  | PERIOD   | MAXIMUM AMOUNT  |
|--|----------|---|
| I. Substance Abuse & Hospice Care                                | Annual   | Not to be less than the State mandated minimum benefit. |
| II. All other Benefits (Hospital, Surgical, Mental Health, Etc.) | Lifetime | Not to exceed \$5,000,000 per person, lifetime.         |

II. ANNUAL DEDUCTIBLE AMOUNT AND COPAYMENTS:

| BENEFIT                        | ANNUAL DEDUCTIBLE | MAXIMUM COPAYMENT |
|--------------------------------|-------------------|-------------------|
| IN-HOSPITAL CARE               | \$1,000/\$2,000*  | 80% MPL           |
| Emergency Accident Outpatient  | \$1,000/\$2,000   | 80% MPL           |
| Emergency Medical Outpatient   | \$1,000/\$2,000   | 80% MPL           |
| MEDICAL-SURGICAL CARE          | \$1,000/\$2,000   | 80% MPL           |
| OTHER HEALTH CARE              | \$1,000/\$2,000   | 80% MPL           |
| Professional Ambulance Service | \$1,000/\$2,000   | 80% MPL           |
| Private Duty Nursing           | \$1,000/\$2,000   | 50% MPL           |
| MISCELLANEOUS HEALTH CARE      | \$1,000/\$2,000   | 80% MPL           |
| MENTAL HEALTH CARE             |                   |                   |
| Inpatient Psychiatric          | \$1,000/\$2,000   | 50% MPL           |
| Outpatient Psychiatric         | \$1,000/\$2,000   | 50% MPL           |
| Inpatient Substance Abuse      | \$1,000/\$2,000   | 50% MPL           |
| Outpatient Substance Abuse     | \$1,000/\$2,000   | 50% MPL           |
| OTHER BENEFITS                 |                   |                   |
| Home Health Care               | \$1,000/\$2,000   | 80% MPL           |
| Hospice Care                   | \$-0-             | 100% MPL          |

\* The \$1,000/\$2,000 annual deductible (\$1,000 per individual/\$2,000 per family)