PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

for the

ALBION COLLEGE
EMPLOYEE BENEFIT PLAN

Revised, November 8, 2018

Amended, March 2, 2018

INTRODUCTION

Albion College ("Employer") has established the Albion College Employee Benefit Plan ("Plan"). Some of the benefits under the Plan (specifically, the medical/prescription drug and dental benefits) are provided on a self-funded basis, which means that benefits will be paid by Employer from its general assets rather than through a separate trust fund or an insurance company.

This document, coupled with the Your Benefits Guide booklet and the Benefits-at-a-Glance Schedules of Benefits from Blue Cross Blue Shield of Michigan (the claim administrator for the self-funded medical/prescription drug and dental benefits), sets forth the terms of the Plan as of July 1, 2011 and is intended to serve as both the Plan document and the Summary Plan Description for the self-funded medical/prescription drug and dental benefits. However, Blue Cross Blue Shield of Michigan is not the insurer of those benefits and any and all references in the booklet(s) to Blue Cross Blue Shield of Michigan should be interpreted accordingly.

Other benefits under the Plan, such as vision, group term life and accidental death and dismemberment ("AD&D") and long-term disability are provided on a fully-insured basis. This document plus the certificates or booklets from the insurers is intended to serve as the Summary Plan Description for those fully-insured benefits.

All references in this document to "Employer" mean Employer. The existence of the Plan does not grant you any legal right to continue employment with Employer or affect the right of Employer to discharge you.

If you have any questions about your benefits under the Plan, please contact the Human Resources Department.

ALBION COLLEGE

Dated: _____ By_____

Its_____

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EMPLOYEE BENEFIT PLAN

The Employee Benefit Plan allows the Employee to provide eligible employees with a choice between cash and certain qualified benefits without adverse tax consequences. Employees who participate in the Employee Benefit Plan can elect to pay for qualified benefits, such as group health insurance, on a pretax basis. This reduces both the employees' and the employer's tax liability. However, once an employee makes such a pretax election, he or she may not change that election to add or terminate an elected coverage, until the next plan year, unless the employee experiences a permitted election change event.

The Employee Benefit Plan is an "umbrella plan." It consists of health and welfare benefit plans (each called a "Sub-Plan") for employees of Albion College. The Sub-Plans provide the following benefits:

- Group medical/prescription drug coverage and dental coverage for employees and their eligible dependents.
- Voluntary group vision coverage for employees and their eligible dependents.
- Group term life and AD&D insurance coverage. (This coverage applies only to employees.)
- Group long-term disability insurance coverage for non-occupational disabilities. (This coverage applies only to eligible employees.)
- Employee assistance plan (EAP) benefits for employees and their eligible dependents.
- Two supplemental income insurance policies are available: critical illness and accident/injury. This voluntary benefit requires premium payments paid pre-tax or after-tax and vary depending on the level of coverage selected

You have already received a summary plan description, insurance certificate, booklet or other documentation describing each Sub-Plan in which you are eligible to participate. This document is intended to supplement those materials.

This document does not replace the provisions of the plan documents and summary plan descriptions for a Sub-Plan or the master plan and/or group insurance contract for a Sub-Plan, including any applicable certificates and/or riders.

The documentation from the insurer/third party administration/ will contain the following information:

- A summary of benefits.
- With respect to health benefits, a description of any deductibles, coinsurance or copayment amounts.

- A description of any annual or lifetime caps or other limits on benefits.

- With respect to health benefits, whether and under what circumstances preventive services are covered.

- With respect to health benefits, whether and under what circumstances prescription drugs are covered.

- With respect to health benefits, whether and under what circumstances coverage is provided for medical tests, devices and procedures.

- With respect to health benefits, provisions governing the use of network providers (if any). If there is a network, the documentation will contain a general description of the provider network and participants will be entitled to obtain a list of providers in the network.

- With respect to health benefits, whether and under what circumstances coverage is provided for any out-of-network services.

- With respect to health benefits, any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.

- With respect to health benefits, any conditions or limits applicable to obtaining emergency medical care.

- With respect to health benefits, any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.

- A description of the circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that the employee might otherwise reasonably expect the Plan to provide.

EMPLOYEE ELIGIBILITY AND PARTICIPATION

Full-Time Faculty and Administrative Employees

Except as provided in the "Ineligible Employees" subsection below, each full-time faculty and administrative employee of Employer who is regularly scheduled to work at least 32 hours per week will be eligible to receive all of the coverages under the Plan. A newly-eligible employee is eligible to participate in the medical/prescription drug, dental, vision, EAP and life insurance benefits on the employee's first day of employment in an eligible job classification. A newly-eligible employee will be eligible to e in the supplemental income insurance benefit after completing 30 days employment. A newly-eligible employee will be eligible to participate in the LTD disability benefit on the first day of the month after completing 12 months of employment in an eligible job classification.

Except as provided in the "Ineligible Employees" subsection below, faculty and administrative employees who are regularly scheduled to work at least 30 hours per week are eligible to participate in the medical/prescription drug, dental, vision and EAP benefits. A newly eligible employee is eligible to participate in these benefits on the employee's first day of employment in an eligible job classification.

Union Employees

Each employee covered by a collective bargaining agreement is eligible to participate in the Plan as provided in the applicable collective bargaining agreement.

Ineligible Employees

The following employees are not eligible to participate in the Plan:

- Employees who normally work six (6) months or less per year (such as assistant coaches and instructional staff who are expected to be employed for only 1 semester.), regardless of your eligibility under the Patient Protection and Affordable Care Act, the PPACA.
- Employees whose primary role is that of student;
- Employees who are not citizens of the Unites States, who reside and are employed outside the United States, and whose compensation from Employer does not constitute income from sources within the United States;
- Employees who perform services for Employer pursuant to an agreement between Employer and another person or entity, such as an employment agency or an employee leasing organization; or
- Employees who perform services for Employer pursuant to a written agreement with Employer that does not provide for participation in the Plan.
- Variable hours employees, regardless of your eligibility under the Patient Protection and Affordable Care Act, the PPACA.

DEPENDENT ELIGIBILITY AND PARTICIPATION

An employee's eligible dependents may also participate in certain benefits under the Plan. Eligible dependents include an employee's spouse or domestic partner and child(ren) as follows:

Spouse

"Spouse" means an employee's legal spouse. An eligible employee can elect coverage for his/her spouse under the medical/prescription drug, dental and vision benefits. An employee's spouse is also eligible for the EAP benefit.

Domestic Partner

"Domestic Partner" means an employee's same or opposite sex partner where all of the following requirements are satisfied:

- The employee and partner are each other's sole partner and are not married to or legally separated from any other person;
- The employee and partner are both at least age 18;
- The employee and partner are not related by blood to a degree of closeness which would prohibit legal marriage if they were not of the same gender;
- The employee and partner live together at the same residence and have done so for at least the prior 12 months;
- The employee and partner are engaged in a committed relationship of mutual caring and support and are jointly responsible for their common welfare and living expenses as demonstrated to the plan administrator in an affidavit for domestic partnership benefits document; and
- The employee and partner are not in the relationship solely for the purpose of obtaining College-provided benefits.

Child

An eligible employee can elect coverage for his/her eligible child under the medical/ prescription drug, dental and vision benefits. An employee's child is also eligible for the EAP benefit.

An employee's eligible dependent child includes the employee's child through the last day of the month during which he or she attains age 26. It also includes an employee's disabled child of any age who is unmarried, incapable of self-support and claimed by the employee as a dependent on the employee's income tax return, provided the disability began before the age of 19.

Child includes a natural child, stepchild, legally adopted child, a child placed for adoption, foster child, and a child who is placed under the employee's care or the employee's spouse's care as the court-appointed permanent or limited guardian (other than a temporary guardian).

An employee's eligible dependents may begin to participate in the Plan on the same day the employee's coverage begins. If a dependent becomes eligible to participate after the employee initially becomes eligible (for example, the dependent is born to or adopted by the employee after the employee's initial eligibility date), the dependent can be immediately enrolled in the Plan provided the employee notifies the Human Resources Department and requests enrollment within 30 days after the dependent first becomes eligible to participate in the Plan.

ANNUAL AND SPECIAL ENROLLMENT PERIODS

Annual Enrollment

Each year, eligible employees may elect medical/prescription drug, dental and vision benefits for themselves and their eligible dependents by completing and submitting an election form during the open enrollment period. The election will become effective on the first day of the following plan year (July 1) and will remain in effect through the last day of the plan year (June 30). Each year, eligible employees may also elect flexible spending accounts and supplemental income insurance benefits for themselves and their eligible dependents by completing and submitting an election form during the open enrollment period. The election for these will become effective on the first day of the following calendar year (January 1) and will remain in effect through the last day of the calendar year (December 31). Other benefits are provided automatically, including group term life insurance, long term disability insurance and the EAP benefit.

Special Enrollment

If an individual experiences a loss of coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in medical coverage under the group health plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), a benefit package option is terminated unless the individual is provided a current right to enroll in alternative health coverage, or coverage is lost due to the application of the other plan's maximum lifetime limit on all benefits.

- A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage.

- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.

- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of an individual who loses other coverage due to the application of a plan's lifetime limit on all benefits, special enrollment rights continue until 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit. Further, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

Employer makes contributions under the Plan on behalf of the employees who participate in the Plan. Employer applies the contributions under the Plan to provide group health and welfare coverage. Employees may be required to contribute to the cost of coverage. If employees are required to contribute to the cost of coverage, Employer will notify employees of the required contribution. The employee's required premiums may be paid under Employer's Flexible Benefits Plan on a pre-tax basis or on an after-tax basis. Benefits under the Sub-Plans are funded in the following manner:

Self-Insured

Benefits under the Sub-Plan may be funded on a self-insured basis. If this is the case, Employer will pay benefits under that Sub-Plan from its unrestricted general assets. Employer may establish a separate bank account for the payment of self-insured benefits. If a separate bank account is established, however, it will be for bookkeeping purposes only.

Insured

Employer may purchase insurance either to provide benefits under a Sub-Plan or, in the case of a Sub-Plan funded on a self-insured basis, to protect Employer from large individual and aggregate losses.

The summary plan description, insurance certificate or booklet describing each Sub-Plan will indicate the basis under which Employer funds that particular Sub-Plan (i.e., self-insured or insured). As previously noted, the medical/prescription drug benefit and dental benefit are funded on a self-insured basis. The medical flexible spending account portion of Employer's Flexible Benefits Plan is also funded on a self-insured basis.

COVERAGE DURING LEAVES OF ABSENCE

In order to remain eligible for coverage under the Plan, the employee must continue to meet the eligibility requirements described in the "EMPLOYEE ELIGIBILITY AND PARTICIPATION" section of this document. However, coverage under the Plan can be continued if the employee goes on a family or medical leave, as defined by the Family and Medical Leave Act of 1993 (FMLA). Coverage will also continue during other employer-approved leaves of absence.

The employee must pay the same premium amount for coverage during FMLA leaves and other approved medical leaves as actively-working employees. While on an approved non-medical leave, the employee must pay 100% of the cost of the coverage.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 ("FMLA") applies to the Plan during any calendar year when Employer employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (i.e., participating employees who have been employed by Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

A participating employee on an FMLA leave may continue coverage during the leave on the same basis and at the same participant contribution rate as if the employee had continued in active employment continuously for the duration of the leave. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is generally available.

TERMINATION OF COVERAGE

Except for an FMLA leave or other employer-approved medical leave of absence, all coverage for an employee and the employee's dependents ends on the date the employee no longer meets the eligibility requirements described in this document.

Coverage will also end if the employee fails to make required premium contributions on a timely basis, if a particular benefit or the entire Plan is terminated, or if coverage is terminated for cause (for example, for fraud or misrepresentation in an application for enrollment or a claim for benefits). If coverage is terminated for cause, the employee may not reinstate coverage for the duration of the employee's employment (or any re-employment) with Employer. Coverage also ends upon voluntarily withdrawal from participation during an annual open enrollment period or in the event of a change in status or other qualifying event.

Coverage for an employee's spouse ends when the employee's coverage ends, or if earlier, on the last day of the month in which the employee is divorced or otherwise no longer legally married to the spouse. Coverage for the employee's children will end when the employee's coverage ends, or if earlier, when no longer an eligible dependent (see above).

In certain circumstances, employees and/or their eligible dependents may be eligible for COBRA continuation coverage, continuation of health coverage upon a military leave, and/or a conversion policy, as explained below.

CONVERSION PRIVILEGES

When an employee or one of the employee's dependents is no longer eligible under the Plan (either as an active participant, the eligible dependent of an active participant or as a qualified beneficiary receiving continuation coverage), the employee and/or dependents may be eligible to obtain an individual conversion policy for one or more of the insured benefits. The availability of this conversion coverage and the rules concerning eligibility are set forth in the applicable policy.

SPECIAL RULES THAT APPLY TO HEALTH BENEFITS UNDER THE PLAN

There are several special rules that apply to the health benefits under the Plan but do not apply to the other welfare benefits (such as long term disability and group term life insurance). This section summarizes those special rules.

Qualified Medical Child Support Orders

Notwithstanding any contrary provision in this document or in any policy or other document describing a health benefit under the Plan, an eligible dependent child may include a child for whom the employee is required to provide coverage pursuant to a qualified medical child support order (QMCSO). Employees may obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

Health Care Reform

The medical/prescription drug and dental benefits under the Plan will be amended to comply with the insurance market reforms of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) as of July 1, 2011. Collectively, the PPACA and the HCERA are known as Health Care Reform. The required changes include the following:

- Dependent children must be eligible to participate in medical/prescription drug and dental benefits under the Plan until at least the child's 26th birthday. Eligibility can be conditioned on the child not being eligible for other employer-sponsored coverage. Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before the attainment of age 26 are eligible to enroll in the Plan effective as of July 1, 2011. Individuals may request enrollment for such dependent children during the 30-day open enrollment period for the plan year beginning July 1, 2011.

- Lifetime limits on the dollar value of essential health benefits under the Plan may no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the Plan effective as of July 1, 2011, and may request enrollment during the 30-day open enrollment period for the plan year beginning July 1, 2011.

- Annual limits on the dollar value of essential health benefits under the Plan must be no lower than $750,000 for the 2011 plan year, $1.25 million for the 2012 plan year and $2 million for the 2013 plan year. No annual limits on the dollar value of essential health benefits under the Plan will apply for plan years beginning on or after January 1, 2014.

- Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage. Thirty days advance notice is required before coverage may be retroactively terminated.

- The Plan may not impose a pre-existing condition limitation or exclusion with respect to a participant under age 19.

Note: Vision benefits provided under the Plan are "excepted benefits" not subject to Health Care Reform. However, Employer has voluntarily amended the definition of dependent child under the voluntary vision benefit as of July 1, 2011 to align with the new definition of dependent child under Health Care Reform.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, provides participants with the following rights:

Pre-Existing Conditions/Certificates of Creditable Coverage

Group health plans may not impose pre-existing condition exclusions with respect to individuals beyond 12 months (18 months for late enrollees). Further, an individual's period of creditable coverage under another health plan must reduce the pre-existing condition exclusion. Group health plans and health insurance issuers must provide individuals with a certificate of creditable coverage following termination of coverage. Individuals may also request a certificate of creditable coverage if the request is made within 24 months after coverage ends. Such a request should be made to the insurance carrier or Employer.

Privacy and Security

Group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private and must maintain and follow privacy policies and procedures. Participants will receive notice of the Plan's HIPAA privacy practices. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements.

Michelle's Law

Effective as of July 1, 2010, pursuant to a federal law known as Michelle's Law, if a serious illness or injury requires a dependent child to change from full-time to part-time student status or take a leave of absence from a college, university or other accredited educational institution, medical/prescription drug coverage may be temporarily extended if all of the following requirements are satisfied:

- The dependent child was enrolled in the Plan on or before the reduction in status or leave of absence began;
- The reduction in status or leave of absence would have otherwise caused the dependent child's coverage under the Plan to terminate; and
- The dependent child's attending physician provides a written certification which states that the reduction in status or leave of absence is medically necessary and due to a serious illness or injury.

If all of the above requirements are satisfied, medical/prescription drug coverage will be extended until the earliest of the following dates:

- One year after the date on which student status was reduced from full-time to part-time;

- One year after the date on which the leave of absence began;

- The date on which the reduction in status or leave of absence is no longer medically necessary; or

- The date on which the child's coverage would otherwise terminate under the Plan (for example, due to the attainment of the limiting age).

After this temporary extension period ends COBRA continuation coverage may be available.

Note: Pursuant to Health Care Reform, a child's full-time student status may no longer impact his or her eligibility for medical/prescription drug benefits under the Plan. As a result, Michelle's Law has no application under the Plan as of July 1, 2011.

COBRA Continuation Coverage

Continuation coverage is required under the federal law known as COBRA. COBRA continuation coverage allows the employee and/or his or her dependents (including a child for whom the employee is required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end.

The plan administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. The employee and his or her spouse (if any) will be informed if a COBRA administrator is appointed and which responsibilities the COBRA administrator has assumed, including whether notices required to be provided to the plan administrator should be sent to the COBRA administrator. The employee may also have continuation coverage rights with respect to his or her medical flexible spending account under Employer's Flexible Benefits Plan.

Eligibility

The employee and/or his or her dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours* or termination of employment**	Employee and Dependents	18
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation***	Dependents	36

* A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause an employee's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

** Continuation coverage is not available if employment is terminated for gross misconduct.

*** Elimination of the employee's spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example), is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

Extension of Continuation Coverage

If the employee and/or his or her dependents become entitled to continuation coverage as a result of the employee's termination of employment or reduction in hours, the 18-month continuation period may be extended for the employee and/or his or her dependents in the three circumstances described below ("extension events").

Second Qualifying Event

If a second qualifying event that is a divorce, legal separation, the employee's death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), the employee's dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the employee's termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided to the plan administrator within 60 days of the date of the second qualifying event.***

Employee's Entitlement to Medicare

If the employee becomes entitled to Medicare benefits during the initial 18-month period, his or her dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, the employee's entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which the employee became entitled to Medicare.***

A special rule applies if the employee became entitled to Medicare before his or her termination of employment or reduction in hours. In that situation, the maximum continuation period for the employee's dependents may be extended, and may end on the later of: 36 months after the date of the employee's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the employee's termination of employment or reduction in hours.***

Social Security Disability Determination

If it is determined that the employee or one of his or her dependents is entitled to Social Security disability benefits either before the employee's termination of employment or reduction in hours or within 60 days after the employee's termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are his or her family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of the employee's termination***

of employment or reduction in hours, if later) and before the end of the 18-month continuation period.

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The plan administrator will provide the employee and his or her spouse (if any) with certain information regarding their rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted in accordance with the requirements described in the "Notice Procedures" subsection.

Notice of Unavailability of Continuation Coverage

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation or a dependent child's loss of eligibility for health coverage under the Plan.

- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by the plan administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, the employee and/or his or her dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. The employee and/or his or her dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

The employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, the employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

The plan administrator has a form which may be used to provide the required notice. The form may be obtained by contacting the plan administrator at the address or telephone number on the last page of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

- The name of the employee or former employee.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance.
- If the notice relates to the employee's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or

- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Special Trade Adjustment Assistance Election

Special COBRA rights may apply to the employee if he or she terminates employment or experiences a reduction of hours and qualifies for a "trade adjustment allowance" or "alternative trade adjustment assistance" under federal trade laws. In this situation the employee is entitled to a second opportunity to elect COBRA continuation coverage for himself or herself and certain family members (if they did not already elect COBRA continuation coverage), but only within a

limited period of 60 days (or less) and only during the six months immediately after group health plan coverage ended. In certain circumstances, you may also be eligible to continue COBRA beyond the normal 18 or 36-month maximum continuation period (see the plan administrator for details).

If an employee qualifies or may qualify for assistance under the federal trade laws, he or she should contact the plan administrator for additional information. The employee must contact the plan administrator promptly after qualifying for assistance under the federal trade laws or he or she will lose these special COBRA election rights.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical/ prescription drug, dental and vision coverages which are provided by Employer pursuant to any separate group health plans and/or which may be separately elected pursuant to Employer's Flexible Benefits Plan, if applicable. However, each coverage is initially available only if the qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However,

no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

Coverage Terminated

Employer no longer offers a group health plan to any of its employees.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Other Coverage

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision will not apply during any time period the other group health plan contains an exclusion or limitation with respect to any pre-existing conditions, other than an exclusion or limitation which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to HIPAA.

Medicare

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).

Cause

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

Questions

Employees and/or their dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description if they have questions regarding COBRA that are not answered in this Summary Plan Description. They may also contact the nearest District or Regional office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Plan Administrator Informed of Address Changes

To protect their rights under COBRA, it is important that the employee and his or her dependents keep the plan administrator informed of any changes in address. They should also keep a copy, for their records, of any notices they send to the plan administrator.

Continuation of Health Coverage Upon Military Leave

If an employee ceases to be eligible for health coverage under the Plan due to service in the U.S. military, the employee and his or her eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The employee and his or her dependents may also be entitled to elect to continue health coverage under COBRA if the employee ceases to be eligible for health coverage due to his or her military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

An employee may elect to continue health coverage under the Plan for himself or herself and his or her eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day the employee is absent from work to perform military service; or

- The period beginning on the first day the employee is absent from work to perform military service and ending with the date the employee fails to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If an employee gives Employer advance notice of a period of military service that will be 30 days or less, the plan administrator will treat the employee's notice as an election to continue health coverage during his or her military service unless the employee specifically informs Employer, in writing, that he or she wants to cancel health coverage during his or her military leave. The employee will have to pay the required premiums for his or her health coverage, but the employee will not have to complete any additional forms or paperwork to continue health coverage during his or her military service.

If an employee gives Employer advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide the employee with a notice of his or her right to elect to continue health coverage pursuant to USERRA and a form for the employee to elect USERRA continuation coverage for himself or herself and his or her eligible dependents. Unlike COBRA, the employee's dependents do not have a separate right to elect USERRA coverage. If the employee wants USERRA continuation coverage for any member of his or her family, the employee must elect it for himself or herself and all eligible dependents who are covered under the Plan when the employee's military service begins.

If an employee chooses USERRA continuation coverage, he or she must return the USERRA election form to the plan administrator within 60 days of the date it was provided to the employee. If the employee does not timely return the election form, USERRA continuation coverage will not be available to the employee and his or her eligible dependents.

A special rule applies if the employee does not give Employer advance notice of his or her military service. In that case, the employee and his or her eligible dependents will not be provided with USERRA continuation coverage during any portion of the employee's military service, but the employee can elect to reinstate health coverage (and the coverage of his or her eligible dependents) retroactive to the first day the employee was absent from work for military service under the following circumstances:

- The employee is excused from providing advance notice of his or her military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for the employee to provide advance notice or the advance notice was precluded by military necessity);

- The employee affirmatively elects to reinstate the coverage; and

- The employee pays all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, the employee's required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If the employee's period of military service is more than 30 days, beginning on the 31st day of his or her military service the employee's required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if the employee does not timely pay any required premiums for health coverage. If the employee's USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated. The initial premium must be paid within 45 days after the date the employee elects USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the employee initially elects USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of the employee's USERRA continuation coverage.

If the employee complies with USERRA upon returning to active employment after military service, the employee may re-enroll himself or herself and his or her eligible dependents in health coverage immediately upon returning to active employment, even if the employee and his or her eligible dependents did not elect USERRA continuation coverage during the employee's military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program ("EAP") is designed to assist employees and their dependents in addressing and resolving personal problems. The purpose of the EAP is to provide problem identification, assessment, and counseling services. The EAP is considered part of this Plan. The EAP provides referral services and a limited number of outpatient counseling sessions.

CLAIM AND APPEAL PROCEDURES

The summary plan description, insurance certificate(s) or booklet(s) from the third party administrator(s) and the insurer(s) for a Sub-Plan that are coupled with this document contain a summary of the claims procedures. However, the claims procedures must provide claims and

appeal rights at least as favorable the procedures described in this section. These claim and appeal procedures also apply to the flexible spending accounts under Employer's Flexible Benefits Plan.

Initial Decision

A claimant will be notified of a benefit determination as follows:

Urgent Care Health Claims

An urgent care health claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit determination regarding an urgent care health claim within 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

Pre-Service Health Claims

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Post-Service Health Claims

A post-service health claim is a claim for a health benefit which is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Concurrent Care Health Claims

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination), will constitute an adverse benefit determination. Notice will be provided in accordance with the "Benefit Determination Notice" subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Disability Claims

If a disability claim is denied, in whole or in part, the claimant will be notified of the adverse benefit determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be made. If, prior to the end of the first 30-day extension period, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be made within the first 30-day extension period, the time for making the determination may be extended for up to an additional 30 days provided the Plan notifies the claimant, prior to the expiration of the first 30-day extension period, of

the circumstances requiring the extension and the date as of which a decision is expected to be made. Any extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The claimant will be granted 45 days within which to provide the required information. The Plan's period for making the benefit determination will be the 30-day period beginning on the date the claimant responds to the request for additional information. If the claimant does not provide the additional information within 45 days from the date of the receipt of the extension notice, the Plan may issue a denial of the claim within 30 days after the end of the 45-day period.

Other Welfare Claims

If a claim for another welfare benefit (such as group term life insurance) is denied, in whole or in part, the Plan must notify the claimant of the adverse benefit determination within 90 days after receipt of the claim, unless the Plan determines that special circumstances require an extension of the time for processing the claim. If the Plan determines that an extension of time for processing the claim is required, written notice of the extension will be furnished to the claimant before the end of the initial 90-day period. In no event will the extension exceed a period of 90 days from the end of the initial period. The extension will indicate the circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Benefit Determination Notice

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review procedures and related time limits and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA (a federal law) following an adverse benefit determination on review.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

Appeal of Denial

The claimant may request a review of an adverse benefit determination regarding a health or disability claim by submitting a written application to the Plan within 180 days following

the denial of the claim. However, in the case of an adverse benefit determination regarding a welfare benefit claim such as group term life/AD&D insurance, the time deadline is 60 days rather than 180 days. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment for (in whole or in part) a benefit.

The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon.

In the case of an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing and all necessary information including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly expeditious method.

Final Decision

The Plan will make a decision regarding a request for review as follows:

Urgent Care Health Claims

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

Pre-Service Health Claims

There will be one or two levels of appeal for pre-service health claims. In either case, the appeal process must be completed within 30 days and notification must be provided to the claimant.

Post-Service Health Claims

There will be one or two levels of appeal for post-service health claims. In either case, the appeal process must be completed within 60 days and notification must be provided to the claimant.

Disability Claims

The claimant will be notified of the Plan's determination on review regarding a disability claim within 45 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination unless the Plan determines that special circumstances require an extension of time for processing the appeal. If the Plan determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 45-day period. In no event will such an extension exceed a period of 45 days from the end of the initial period. The notice will indicate the special circumstance requiring an extension and the date by which a decision is expected to be made.

Other Welfare Claims

The claimant will be notified of the Plan's determination on review regarding a welfare benefit claim such as group term life insurance within 60 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination unless the Plan determines its special circumstances require an extension of time for processing the appeal. If the Plan determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 60-day period. In no event will an extension exceed a period of 60 days from the end of the initial period. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected to be made.

Legal Actions

No legal action may be brought to recover benefits under the Plan until the participant has exhausted the claim review procedure. Further, with respect to the self-insured benefits under the Plan, no legal action may be brought after the expiration of one year after the participant has been provided with a written notice denying the final level of Plan appeal concerning a claim.

ADMINISTRATION

Employer is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan.

With respect to the self-insured benefits, Employer, as the plan administrator, has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the Plan.

However, the fully insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy.

AMENDMENT OR TERMINATION

Although Employer intends to maintain the Plan indefinitely, Employer has the authority to amend or terminate the Plan or any Sub-Plan at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits. Participants will be informed of any material amendment affecting their coverages or changing the operation of the Plan.

HIPAA PRIVACY AND SECURITY RULES

This section applies to the health benefits under the Plan and is required by the privacy and security rules of HIPAA.

Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")

Subject to obtaining written certification (see below), the Plan may disclose PHI to Employer, provided Employer does not use or disclose such PHI except for the following purposes:

- Performing Plan Administrative Functions which Employer performs for the Plan.
- Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or
- Modifying, amending or terminating the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event will Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure

Employer agrees that with respect to any PHI, it will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Employer with respect to PHI.

- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Employer.

- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

- Make available to a participant who requests access, the participant's PHI in accordance with 45 CFR §164.524.

- Make available to a participant the right to request an amendment to the participant's PHI and incorporate any amendments to the participant's PHI in accordance with 45 CFR §164.526.

- Make available to a participant who requests an accounting of disclosures of the participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

- Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.

- If feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that the adequate separation between Plan and Employer, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that terms set forth below are followed.

- Employer further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Employer will ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Employer will report to the Plan any security incident of which it becomes aware.

Certification of Employer

The Plan will disclose PHI to Employer only upon the receipt of a certification by Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Employer agrees to the conditions of disclosure set forth above.

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to Employer, provided such Summary Health Information is only used by Employer for the purpose of:

- Obtaining premium bids from health plan providers for providing health coverage under the Plan; or

- Modifying, amending or terminating the Plan.

Adequate Separation Between Plan and Employer

- The employees, or classes of employees, listed in Employer's HIPAA privacy policies and procedures will be given access to PHI.

- The access to and use of PHI by the individuals described above will be restricted to the Plan Administrative Functions that Employer performs for the Plan.

- In the event any of the individuals described above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the plan administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

- To comply with the HIPAA security rules, Employer will ensure that the provisions of this section are supported by reasonable and appropriate

security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

Disclosure of Certain Enrollment Information to Employer

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Employer information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

Employer authorizes and directs the Plan, through the plan administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the HIPAA privacy rules.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the HIPAA privacy rules.

Definitions

For purposes of this section, the following terms have the following meanings:

- **"Business Associate"** means a person or entity who:
    - Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.); or
    - Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.
- **"Plan Administrative Functions"** mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administrative functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans–such as dental. PHI for these purposes may not be used by or between the Plan or business associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan administrative functions specifically do not include any employment-related functions.

- **"Protected Health Information"** or **"PHI"** means information that is created or received by the Plan, or a business associate of the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant (whether living or deceased). The following components of a participant's information are considered to enable identification:

    - Names;
    - Street address, city, county, precinct, zip code;
    - Dates directly related to a participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;
    - Telephone numbers, fax numbers and electronic mail addresses;
    - Social Security numbers;
    - Medical record numbers;
    - Health plan beneficiary numbers;
    - Account numbers;
    - Certificate/license numbers;
    - Vehicle identifiers and serial numbers, including license plate numbers;
    - Device identifiers and serial numbers;
    - Web Universal Resource Locators (URLs);
    - Biometric identifiers, including finger and voice prints;
    - Full face photographic images and any comparable images; and
    - Any other unique identifying number, characteristic or code.

- **"Summary Health Information"** means information that may be individually identifiable health information:

- That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Employer has provided health benefits under a health plan; and

- From which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

Fully-Insured Health Plans Administered Under "Hands Off" Approach

Pursuant to HIPAA, if a group health plan is fully-insured and only enrollment/disenrollment information and Summary Health Information rather than Protected Health Information is disclosed to Employer and Employer only uses the Summary Health Information to obtain premium bids and/or to amend/terminate the Plan, then the responsibility to comply with the HIPAA privacy rules generally shifts from the Plan to the insurer. This is known as the "hands off" approach to administration. Any fully-insured health benefits under the Plan which are administered under the hands off approach shall not otherwise be subject to the HIPAA privacy and security rules set forth in this Article (i.e., simply because they are included in the Plan for Form 5500 filing purposes).

Hybrid Entity

To the extent the Plan provides any non-health benefits such as (but not limited to), disability benefits or group term life insurance benefits, those benefits shall be considered "non-covered functions." The Plan is a separate legal entity whose business activities include the functions covered by the HIPAA privacy and security rules and non-covered functions. As a result, the Plan is a hybrid entity, as that term is defined in HIPAA. The Plan's covered functions are its health benefits ("health care component"). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy and security rules with respect to the health care component (the health benefits) of the Plan.

GOVERNING LAW

The Plan is primarily subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as well as other various federal laws, including, but not limited to, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, HIPAA, Michelle's Law, FMLA, COBRA, USERRA and Health Care Reform, as well as certain state insurance laws. However, the Plan may include certain benefits (such as a dependent care flexible spending account) that are not subject to ERISA.

To the extent not preempted by the federal law known as ERISA, the Plan will be construed in accordance with the laws of the state of Michigan.

FORM 5500

The health and welfare benefits described in this Plan shall be considered a single plan for purposes of satisfying any obligation to file an annual Form 5500.

PLAN PARTICIPANTS' RIGHTS

Notwithstanding anything to the contrary in a booklet or certificate, participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

Information About the Plan and its Benefits

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the plan administrator's office, and at other specified locations, such as work sites and union halls all documents governing the Plan, including any insurance contracts, collective bargaining agreements and if 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, any updated Summary Plan Description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report if there are 100 or more participants in the Plan and the Plan is not funded solely through Employer's general assets. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for themselves, spouses or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Participants or their dependents may have to pay for such coverage. Participants should review the rules governing COBRA continuation coverage rights described elsewhere in this Summary Plan Description.

- A reduction or elimination of any exclusionary periods of coverage for pre-existing conditions under the Plan, if the participants have creditable coverage from another plan. A participant should be provided a certificate of creditable coverage, free of charge, from his or her group health plan when coverage is lost, when the participant becomes entitled to elect

COBRA continuation coverage, and when the participant's COBRA continuation coverage ceases, if the participant requests it before losing coverage, or if the participant requests it up to 24 months after losing coverage. Without evidence of creditable coverage, the participant may be subject to any plan pre-existing condition exclusion which may be up to 12 months (or 18 months for late enrollees) after the participant's enrollment date in his or her coverage.

Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of the Plan participants and beneficiaries. No one, including Employer, or any other person, may fire a participant or otherwise discriminate against the participant in any way to prevent the participant from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcement of Rights

If a participant's claim for a welfare benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps participants can take to enforce the above rights. For instance, if a participant requests materials from the plan administrator and does not receive them within 30 days, the participant may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If the participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. In addition, if the participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the participant may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor, or the participant may file suit in federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person the participant sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees, for example, if it finds the participant's claim is frivolous.

Assistance With Questions

If the participant has any questions about the Plan, he or she should contact the plan administrator. If the participant has any questions about this statement ("PLAN PARTICIPANTS' RIGHTS") or about his or her rights under ERISA, or needs assistance in obtaining documents from the plan administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of

Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or viewing its website at www.dol.gov/ebsa.

OTHER BASIC INFORMATION ABOUT THE PLAN

Name of Plan:	Albion College Employee Benefit Plan
Sub-Plans:	Medical and Rx, Dental Plan Voluntary Vision Plan Group Term Life/AD&D Plan Long-Term Disability Plan Short-Term Disability Plan Flexible Benefits Plan Employee Assistance Plan
Name, Address, Telephone Number and Taxpayer Identification Number of Employer:	Albion College 611 East Porter Street Albion, MI 49224 (517) 629-0289 38-1359081
Plan Number:	502
Type of Plan:	Employee Benefit Plan providing group medical, prescription drug, dental, voluntary vision, life/ AD&D, long-term disability, short-term disability, flexible spending accounts and employee assistance program benefits.
Type of Administration:	With respect to the self-insured benefits, the Plan is administered by the plan administrator and the claim administrator(s). With respect to the fully-insured benefits, the Plan is administered by the plan administrator and the insurers(s).
Plan Administrator:	Employer

Name and Address of Agent for Service of Legal Process:	Vice President Finance and Administration Albion College 611 East Porter Street Albion, MI 49224 (517) 629-0289 Service of legal process may also be made on the plan administrator.
Claim Administrator(s)/Insurers:	**For Self-Insured Medical/Prescription Drug and Dental Benefits:** Blue Cross Blue Shield of Michigan Customer Service Center P.O. Box 80200 Lansing, MI 48908-0200 Telephone: (800) 258-8000 **For Fully-Insured Voluntary Vision Benefits:** VSP VSP.com (800)877-7195 **For Fully-Insured Group Term Life/AD&D Benefits:** Standard Insurance Company 900 SW Fifth Avenue Portland, Oregon 97204-1282 Telephone: (800)368-2859 Fax: (800)378-6053 **For Fully-Insured Long-Term Disability Benefits:** Standard Insurance Company 900 SW Fifth Avenue Portland, Oregon 97204-1282 Telephone: (800)368-2859 Fax: (800)378-6053

For Self-funded Short-Term Disability Benefits:

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204
Telephone: (800)368-2859
Fax: (800)378-6053

For Employee Assistance Program Benefits:

Behavioral Health Resources
140 W. Michigan Avenue
Battle Creek, MI 49017
Telephone: (800) 269-5870
(269) 966-1460
www.summitpointe.org

Plan Year:	July 1 through June 30

APPENDIX A
FLEXIBLE BENEFITS PLAN

WHAT IS THE FLEXIBLE BENEFITS PLAN?

The Flexible Benefits Plan allows you to design a benefits package to suit the individual needs of you and your family and provides you with the following benefit choices:

- You may elect to pay your portion of the premium for medical and dental coverage under the Employee Benefit Plan on a pre-tax or after-tax basis.

- You may elect to pay the premium for the voluntary vision coverage which Employer makes available to employees on a pre-tax or after-tax basis.

- If you certify that you have other medical and prescription drug coverage (for example, through your spouse's employer), you may waive Employer-provided medical and dental coverage and receive additional compensation from Employer.

- You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying medical expenses.

- You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying dependent care expenses.

More information regarding the types of tax-free benefits which you may choose and the procedures for making your benefit elections through the Flexible Benefits Plan are explained in the following sections of this Appendix.

References are made throughout this Appendix to the "plan year." The plan year is the 12-month accounting period for the Flexible Benefits Plan, which is July 1 through June 30. Medical/prescription drug, dental and vision benefits are elected on a plan year basis. However, the plan year for electing the reimbursement of medical expenses or dependent care expenses is January 1 through December 31. Any references to "calendar year" also mean the 12-month consecutive period beginning January 1 and ending on December 31.

BENEFIT CHOICES

For each plan year, you may choose from the following benefits:

Medical & Prescription Insurance Benefits

You have two choices with regard to medical/prescription drug coverage for you and your dependents for whom coverage may be purchased on a before-tax basis:

- You may elect to receive the coverage and pay your share of the cost with before-tax or after-tax pay reductions. (The default is pre-tax deductions.)

The cost of your coverage may depend on various factors, such as whether coverage is elected for you only or you and one or more of your dependents.

- You may elect to waive the coverage. If coverage is waived, you must certify that you have alternate medical and prescription drug coverage. The certification must be on a form provided by Employer for this purpose. If health insurance coverage is waived, Employer will pay additional compensation to you in your paychecks during the plan year for which health insurance coverage was waived. Employer will inform you of the timetable for paying the additional compensation (e.g. in equal installments over each pay period or quarterly, in a lump sum at year end, etc.). The additional compensation is subject to tax withholdings.

Dental Insurance Benefits

You have two choices with regard to dental insurance coverage for you and your dependents for whom coverage may be purchased on a before-tax basis:

- You may elect to receive the coverage and pay your share of the cost with before-tax or after-tax pay reductions. (The default is pre-tax deductions.) The cost of your coverage may depend on various factors, such as whether coverage is elected for you only or you and one or more of your dependents.
- You may elect to waive the coverage. If coverage is waived, you must certify that you have alternate medical and prescription drug coverage. The certification must be on a form provided by Employer for this purpose. If health insurance coverage is waived, Employer will pay additional compensation to you in your paychecks during the plan year for which health insurance coverage was waived. Employer will inform you of the timetable for paying the additional compensation (e.g. in equal installments over each pay period or quarterly, in a lump sum at year end, etc.). The additional compensation is subject to tax withholdings.

Voluntary Vision Benefits

Voluntary vision coverage is available to you and your eligible dependents through Employer. If you want this insurance coverage, you may pay the cost with pre-tax or after-tax pay reductions.

Flexible Spending Accounts

You may use pre-tax pay reductions to obtain reimbursement of qualifying medical expenses and/or dependent care expenses (see the "YOUR FLEXIBLE SPENDING ACCOUNTS" section).

COBRA Premiums

If you terminate employment and receive severance pay from Employer, you may elect COBRA and pay your COBRA premiums for health coverage from the severance pay on a pre-tax basis.

TAX EFFECT OF PRE-TAX PAY REDUCTIONS

If you elect medical/prescription drug coverage, dental coverage, voluntary vision coverage, and/or you elect to participate in the flexible spending accounts, your pay will be reduced as provided in the election process. The election procedures will be provided to you during the open enrollment period (see the "CHOOSING YOUR BENEFITS" section below). Your premiums for medical/prescription drug coverage, dental coverage and/or voluntary vision coverage will automatically be paid when they come due. However, if your employment is temporarily interrupted and you do not receive pay, you will still be required to pay your premium amounts when they are due.

"Pre-tax" pay reductions are not taxable for purposes of either income taxes or FICA. Because you do not pay taxes on your pay reductions, it reduces the net cost for your share of the premiums.

The reduction of your pay for purposes of FICA may cause a small reduction in your future Social Security benefits. You should consult with your tax adviser for more information regarding this issue.

CHOOSING YOUR BENEFITS

This section describes the procedure for choosing benefits under the Flexible Benefits Plan. You may generally not change your election during the plan year, except as described below.

Initial Benefit Selection

Generally, you must make an election before the date that you become a participant in the Flexible Benefits Plan. Employer will inform you of the election procedures. The election process may require completion and return of a written election form and/or may require you to make your election electronically such as through an online computer system or telephone system. After you make your choice, you may change your election only during an open enrollment period or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

There is an exception to these rules if you are a new employee who becomes eligible to participate in the Plan on your date of hire. In this situation, if you make your election within the next 30 days after you start working, the election will be retroactively effective to your first day of employment.

If you do not make an election before the date that you become a participant in the Flexible Benefits Plan, you will receive your regular pay through Employer's payroll system for the remainder of the plan year and:

- You will not be eligible for medical/prescription drug coverage, dental coverage or the voluntary vision coverage for the remainder of the plan year.

- You will not be eligible to receive any additional compensation for waiving medical/prescription drug coverage and/or dental coverage.

- Your right to reimbursement from the flexible spending accounts will be waived for the remainder of the plan year.

Annual Benefit Selection

There will be an open enrollment period before the start of each plan year. If you elect to pay your share of the premium for medical/prescription drug coverage, dental coverage and/or or for the voluntary vision coverage on an after-tax basis and/or you elect to participate in the flexible spending accounts, you must make a new election during the open enrollment period for each plan year. The new election will become effective as of the first day of the next plan year and will remain in effect through the last day of the plan year. After the plan year begins, you may change your election only during the next open enrollment period for that particular benefit or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

As previously indicated, there are separate plan years for your election under the Employee Benefit Plan (July 1 through June 30) and your election for the flexible spending accounts (January 1 through December 31).

If you do not make a new election during the open enrollment period, the following default elections will apply:

- Your prior elections regarding medical/prescription drug coverage, dental coverage and the voluntary vision coverage will be continued, but on a before-tax basis. You will be considered to have agreed to pay the appropriate premium (if any) for the subsequent plan year for this coverage. If the insurance option(s) in which you are currently enrolled is not being offered during the subsequent plan year, you will be enrolled in the most similar option.

- No pay reductions will be credited to your flexible spending accounts for the next plan year.

CHANGING YOUR ELECTION DURING A PLAN YEAR

As a general rule, you may only change your benefit election annually during an open enrollment period. However, you may change your election during a plan year in certain situations for which federal law permits a new election. The next sections describe these situations.

Change In Status

A change in status is an exception to the rule prohibiting any change during a plan year in your benefit election. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;
- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;
- An event affecting the employment status of you or your spouse or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, student status, or any similar circumstance; or
- A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election under the Flexible Benefits Plan only if the election change is on account of, and corresponds with, the change in status that affects eligibility for coverage. However, the following special rules apply:

- If you want to decrease or cancel Employer-provided health coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent due to a legal marital or employment change in status, the change will only be permitted if coverage is or will be actually obtained under the other plan.
- With respect to your medical spending account, you may elect to decrease your annual contribution amount, but not below the amount that has already been reimbursed to you for the plan year.

- With respect to your dependent care spending account, an election change may be made if your dependent attains age 13 or becomes or ceases to be totally disabled.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the plan administrator. If you do not make a new election within 30 days after the change in status, you must wait until the next open enrollment period to change your election. Further, any new election involving a third party insurer will only be approved to the extent permitted by the third party insurer.

FMLA Leaves and Other Approved Leaves of Absence

If you go on an FMLA leave, you may continue or revoke your elections regarding medical/prescription drug, dental and vision coverage and/or your flexible spending accounts even if you do not otherwise have a change in status. If you go on an FMLA leave, the following rules apply:

- You may continue or revoke your election of these benefits when you begin your FMLA leave.

- If you continue all or a portion of your election, you must continue making the necessary contributions for the benefits. You should contact Employer to discuss the procedures for making the contributions.

- If you terminated coverage during the FMLA leave, your coverage may be reinstated when you return to work. Reinstatement will occur immediately--no pre-existing condition provision will apply.

- You have the same election rights as an actively working participant during an open enrollment period and if a new or significantly improved benefit or coverage option is offered.

- If you take an <u>unpaid</u> FMLA leave and you receive additional compensation from Employer for waiving medical/prescription drug coverage and/or dental coverage, you will not receive this additional compensation for the time period when you are on the unpaid leave.

- If you terminate coverage in your flexible spending accounts during the FMLA leave, your accounts cannot be used to reimburse expenses incurred during the FMLA leave. Also, your total benefits during the plan year may be reduced on a pro rata basis for the time period in which your coverage was not in effect.

- If you do not return to work at the end of an FMLA leave, your participation in the Plan will terminate.

Special Enrollment Rights Under HIPAA

You may have special rights under HIPAA to enroll in the medical/prescription drug coverage and/or dental coverage in three situations:

- You have lost other group health coverage. This could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums. You must make your new election within 30 days after the event occurs.

- You acquire a new dependent by marriage, birth or adoption. You must make your new election within 30 days after the event occurs.

- Your Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or you become eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under the Employee Benefit Plan. ("CHIP" is a state children's health insurance program.) You must make your new election within 60 days after the event occurs.

Court Order

You may change your election regarding medical/prescription drug coverage, dental coverage or the voluntary vision coverage because of a court order resulting from a divorce, legal separation or change in legal custody that requires health coverage for one or more of your children. Specifically, you may:

- Elect coverage for the child if the court order requires you to add the child to the Employer-provided health coverage in which you are enrolled; or

- Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage and the other coverage is actually provided.

Medicare or Medicaid Coverage

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce coverage for that individual under the Employee Benefit Plan. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase coverage for that individual under the Employee Benefit Plan.

Cost and Coverage Changes

If the cost of the medical/prescription drug coverage, dental coverage or the voluntary vision coverage changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase is significant, you may either agree to the increase, change your election to another comparable benefit option, or drop

coverage if no other comparable benefit option is available. However, medical/prescription and dental coverage may be dropped only if you certify that you have other medical/prescription coverage. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

With respect to your dependent care spending account, if the cost of your dependent care provider changes during the plan year you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative.

If the medical/prescription drug coverage, dental coverage or the voluntary vision coverage is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. However, medical/prescription drug coverage and/or dental coverage may be dropped only if you certify that you have other coverage. Further, if Employer offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse or dependent has a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change under the Employee Benefit Plan.

YOUR FLEXIBLE SPENDING ACCOUNTS

There are certain medical expenses that you or your family may incur that are not covered under the Employee Benefit Plan. Also, if you have children or other dependents, you may have to pay others to provide care for them while you are at work. You may be reimbursed for these medical and dependent care expenses under your flexible spending accounts. Your flexible spending accounts allow you to pay certain qualifying expenses using "before-tax" income rather than "after-tax" income. Your pay reductions are converted into the tax-free reimbursement of certain qualifying expenses.

The flexible spending accounts operate as follows. Employer will establish a separate bookkeeping account in your name for each tax-free reimbursement benefit you choose for a plan year. For example, if you choose both of the tax-free reimbursement benefits available under the Flexible Benefits Plan, Employer will establish the following accounts in your name:

- Medical spending account; and
- Dependent care spending account.

Employer will allocate your pay reductions to each account in the amount indicated in your election. When a claim for reimbursement is paid, the amount paid will be subtracted from the applicable flexible spending account. You may not use amounts allocated to one account to receive reimbursement for another type of benefit.

Medical Spending Account

What Amount of Pay Reductions Should I Allocate to My Medical Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your medical spending account and, if so, how much to reduce your pay. Employer will inform you during the open enrollment period of the minimum and maximum amounts you may have credited to your medical spending account for the plan year.

If you know you will have qualifying medical expenses during the plan year which will not be covered by the Employee Benefit Plan or another health plan in which you participate, you should consider putting enough in your medical spending account to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying medical expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the amount to put in your medical spending account, it is wise not to put in too much. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year (December 31) and the 2½-month grace period (March 15), all unused amounts must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Medical Spending Account?

Qualifying Individuals

Qualifying medical expenses may be incurred for:

- You;
- Your spouse;
- Your natural child, your adopted child, a child placed with you for adoption, your step-child or your foster child through the end of the year in which the child turns age 26; or
- Other children, relatives and members of your household who are your "qualifying child" or "qualifying relative" under IRS guidelines.
    - A qualifying child is your child or other relative who is younger than you, who lives with you, who does not provide more than half of his or her own financial support and who meets certain other requirements. Such an individual will be your qualifying child until

the end of the calendar year in which the individual turns 18 or 23 (if a full-time student). However, this age requirement is waived for a qualifying child who is totally disabled.

- A qualifying relative is your child, other relative, or member of your household for whom you provide over half the individual's financial support and the individual is not the qualifying child of you or any other individual.

Qualifying Medical Expenses

Qualifying medical expenses are generally those types of medical expenses normally deductible on your federal tax return (without regard to the 7.5% of adjusted gross income limitation). They include, for example, expenses you have incurred for:

- Copays and deductibles you must pay before your group health plan begins to pay benefits.

- Vaccines, medicine and drugs that require a prescription (for example, birth control pills).

- Non-prescription drugs purchased to alleviate or treat an illness or injury (for example, an allergy medicine, pain reliever or cold medicine) incurred through December 31, 2010. Effective as of January 1, 2011, over-the-counter drugs and medicines will no longer be eligible for reimbursement under the medical spending account unless specifically prescribed by a physician or the drug is insulin.

- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).

- Medical examinations, x-rays and laboratory services, insulin treatments and whirlpool baths the doctor ordered for a specific medical condition.

- Lasik (laser) eye surgery.

- Nursing help. If you pay someone to do both nursing and housework, only the nursing help may be reimbursed as a qualifying medical expense. However, housework may

qualify for reimbursement under your dependent care spending account.

- Hospital care (including meals and lodging), clinic costs and lab fees.

- Medical treatment at a center for the treatment of alcohol or other substance abuse.

- Medical aids such as hearing aids (and batteries), dentures, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining these aids.

- Ambulance service and other travel costs to get health care. If you used your own car, you may claim what you spent for gas and oil to go to and from the place you received the care, or you may claim the mileage reimbursement rate allowed by federal law. You may add parking and tolls to the amount you claim under either method.

- Expenses for weight-loss programs as a treatment for obesity. This includes the fees to join the program, but not the cost of food.

- Massage therapy prescribed by a physician to treat a medical condition.

- Body scans and other diagnostic procedures, including pregnancy kits, ovulation monitors and on-site health fairs that check items such as blood pressure and cholesterol.

- Teeth whitening to correct discoloration caused by disease, birth defect or injury, but not to correct discoloration caused by aging.

- Cord blood storage if a child is born with a medical condition where cord blood may be needed in the future, but not if storing it just in case of a future need.

Many of the expenses listed above are covered by the Employee Benefit Plan. Any expense covered by that plan or any other source will <u>not</u> be treated as a qualifying medical expense.

Expenses are considered to be incurred when the services are rendered or supplies are provided, not when billed or paid. However, orthodontia services may be reimbursed before the services are provided but only to the

extent that you have actually made payment in advance in order to receive the services. These orthodontia services are deemed to be incurred when you make the advance payment.

Special Rule for Health Savings Account Participants

A health savings account ("HSA") is a tax-favored IRA type of account established for an eligible individual who is covered only by a qualified high deductible health plan. Employer currently does not offer a qualified high deductible health plan, however, Employer is offering a Limited Purpose Flexible Spending Account for employees who have coverage through a high deductible health plan. Employer also offers a general purpose Flexible Spending Account ("FSA"). Employees should refer to their spouse's or family member's employee benefit plan, if applicable, to determine eligibility for a Limited Purpose Flexible Spending Account ("LPFSA").

If you have a spouse or dependent who participates in an HSA and qualified high deductible health plan (for example, through their employer), you should indicate on your election form that you do not want your spouse or dependent to be covered by the medical spending account for the plan year. This is necessary in order for your spouse or dependent to be eligible for HSA contributions because the medical spending account is an ineligible, non-high deductible health plan for HSA purposes.

You are not allowed to contribute to both a health savings account (HSA) as well as standard (non-limited) health FSA – You are eligible for an HSA if you use a limited-purpose FSA for your dental and vision care needs. This will allow you to maximize your savings and tax benefits.

Limited Purpose Flexible Spending Account

Beginning in 2019, Albion College has adopted a Limited Purpose Flexible Spending Account option for its employees who have health insurance coverage through a High Deductible Health Plan ('HDHP'). The Limited Purpose Flexible Spending Account may only be used for reimbursement of dental and vision expenses. The Plan is funded through employee pre-tax contributions deducted from the employee's paycheck each pay period. If you decide to participate in the Limited Purpose Flexible Spending Account (LPFSA), you should review your dental and vision needs for the previous year and elect a contribution amount during the annual Open Enrollment period, which you believe will be in keeping with your anticipated expenses for those needs during the coming year. Under the Limited Purpose FSA, only qualified dental and vision expenses can be reimbursed. Any unused Limited Purpose FSA balance at the end of the year will be forfeited, except

that you will have until March 15th, of the next calendar year, to use those funds for reimbursement of the prior year's qualified expenses.

Eligible Limited Purpose FSA expenses include such things as:

- Dental and vision products;
- Non-cosmetic dental care, orthodontia, eyeglasses, contact lenses, and laser eye surgery; and
- Copays, coinsurance, and deductibles under dental and vision plans.

Non-Qualifying Expenses under Limited Purpose FSA include:

You **cannot** obtain reimbursement for the following expenses:

- The cost of health coverage. For example, you cannot obtain reimbursement for the premium you pay to obtain coverage under the Employee Benefit Plan or for the premium your spouse pays to obtain health coverage under his or her employer's group health plan. You also cannot obtain reimbursement for the premium for an individual health policy. However, you may purchase health coverage under other provisions of the Flexible Benefits Plan (see the "BENEFIT CHOICES" section above).
- Life insurance or income protection policies.
- The hospital insurance benefits tax withheld from your pay as part of the Social Security tax.
- Illegal operations or drugs.
- Non-prescription drugs and medicines used to maintain your good health (for example, dietary supplements and vitamins). Beginning January 1, 2011, all non-prescription drugs and medicines are ineligible unless specifically prescribed by a physician or the drug is insulin.
- Items which are considered toiletries (such as toothpaste) or cosmetics (such as face cream).
- Travel your doctor told you to take for rest or change.
- Items purchased for cosmetic reasons.

- Cosmetic surgery, unless necessary because of injuries you receive, congenital disfigurement, or a disfiguring disease.

- Long-term care expenses.

- Health club dues.

- Expenses reimbursed by an Employer group health plan or any other source.

- Expenses incurred before you begin, or after you stop, making contributions to your medical spending account except to the extent you are eligible to submit claims incurred during the 2½-month grace period.

How Do I Make a Claim for Reimbursement?

You should submit your claims for reimbursement of qualifying medical expenses to Employer, using the required claim form. As part of the claim you will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred, the name and address of the person or entity to which the expense was paid and a statement that the expense has not been paid or reimbursed by, nor will you seek payment or reimbursement under any other employer-sponsored plan, any federal, state, or other governmental plan or program, or any other source.

Your medical spending account resembles an insurance policy. You are entitled to uniform coverage throughout the plan year. For example, if you incur $100 of qualifying medical expenses during the first month of the plan year, you may be reimbursed for those expenses immediately, even if you only have $50 credited to your account during that month. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your medical spending account for the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after Employer receives the claim, but no less frequently as monthly. However, if your total unpaid claims are less than $10, the claims are held and paid when the total exceeds $10. The $10 minimum does not apply, however, at the end of the plan year or subsequent 2½-month grace period and all claims will be paid to the extent of the balance in your medical spending account.

Claims for qualifying medical expenses incurred during a plan year or during the 2½-month grace period ending on the 15th day of the third month (March 15) of the next plan year may be reimbursed out of your account balance for the year.

If you submit a claim that was incurred during the grace period and you have an unused account balance with respect to the plan year just ended, you must designate whether you want the reimbursement paid from that account balance or from your account balance for the next plan year. You may not split a claim for a single item between the account balances for the two plan years. To provide you with the most beneficial use of your account, you should request reimbursement from the account balance remaining for the plan year just ended where appropriate.

All claims for reimbursement must be filed no later than 4½ months (May 15) after the end of the plan year. If you do not timely submit a claim, the claim will be denied. Any amount then remaining in your account will be forfeited (see the "Forfeitures" subsection).

Different rules apply if you terminate participation during the plan year:

- If you terminate participation before the end of the plan year, claims for expenses may only be reimbursed if the claims were incurred during the time period in which you were a participant.

- For this purpose, if you have unused amounts remaining in your account, you will not be considered to have terminated participation in your medical spending account until the earlier of the date those amounts are exhausted through reimbursement of eligible claims or the last day of the plan year.

Your medical spending account is not insured. If for any reason the Flexible Benefits Plan or Employer does not ultimately reimburse you for expenses that are eligible for reimbursement, you may be liable for the expenses.

HIPAA Privacy

The medical spending account is subject to the HIPAA privacy rules. You will receive a notice of Employer's privacy practices which will explain, in detail, the HIPAA privacy rules and your privacy rights.

Dependent Care Spending Account

What is the Difference Between My Dependent Care Spending Account and the Dependent Care Tax Credit?

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "before-tax" income through the Plan. Second, you may claim a tax credit on dependent care expenses (up to $3,000 for one child and up to $6,000 for two or more children). However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the Plan.

What Amount of Pay Reductions Should I Allocate to My Dependent Care Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your dependent care spending account and, if so, how much to reduce your pay. If you know you will have dependent care expenses during the plan year, you should consider putting enough in your dependent care spending account to cover these planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the proper amount to put in your dependent care spending account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation, you should take this into consideration when you determine the amount you want to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year (December 31) and the 2½-month grace period (March 15), all unused amounts must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Dependent Care Spending Account?

Your dependent care expenses may be reimbursed under the Flexible Benefits Plan. Dependent care expenses are your expenses for certain services which your dependents need in order for you to be employed by Employer.

The Internal Revenue Code defines who is considered your dependent for this purpose:

- Your dependent includes a qualifying child who is younger than you, who lives with you for more than half of the year, who does not provide over half of his or her own financial support for the year and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the noncustodial parent for income tax purposes.

- Your dependent also includes a qualifying relative such as your parent who receives over half of his or her financial support for the year from you.

The types of services covered are:

- Care for your dependent in your home (such as babysitting), if the dependent is either:

    - Your qualifying child under age 13; or

- Your spouse or qualifying relative who is totally disabled. A person is totally disabled if the person has a mental or physical condition which makes the person incapable of caring for his or her hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his or her personal safety or the safety of others.

- Care for your dependent outside of your home (such as in a day care center), if the dependent is either:

  - Under age 13; or

  - Totally disabled (as defined above) and regularly spends at least eight hours per day in your home.

  This also includes pay, per an agreement with your daycare provider, which is required in order to hold a place for your child(ren) during your short, temporary absence from work (for example, during vacation or your short term illness).

- Household services for the maintenance of your home (such as for a domestic maid or cook) as long as the services are performed in part for the benefit of your dependent.

May Amounts Paid to My Relatives Be Reimbursed?

You may hire whomever you want to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Flexible Benefits Plan if one of the following relatives provides the care:

- One of your dependents;

- Your spouse; or

- Your child (even if not your dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

Are There Limits on How Much May Be Reimbursed?

Federal law limits the amount of dependent care expenses which may be reimbursed under the Flexible Benefits Plan. Generally, the limit is $5,000 per calendar year (or $2,500 if you are married and file a separate tax return).

However, if you earn less than $10,000 or your spouse earns less than $5,000, the limit is the lesser of your spouse's pay or ½ of your pay. A further limit applies if you and your spouse are filing separate tax returns. If your spouse is a full-time student or is totally disabled (as defined above) for any month in which you have

dependent care expenses, your spouse will be considered to have the following pay for that month:

- $250, if you have dependent care expenses for one dependent; or
- $500, if you have dependent care expenses for more than one dependent.

How Do I Make a Claim for Reimbursement?

You should submit your claims for reimbursement of dependent care expenses to Employer, using the required claim form. As part of the claim you will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the dependent care expense was paid. You will also need to provide or certify that you have obtained the taxpayer identification number (in the case of an entity) or the Social Security number (in the case of a person) of the entity or person that provided the dependent care. You are required to obtain this information in order to report your dependent care expenses with your tax return on IRS Form 2441.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after Employer receives the claim, but no less frequently as monthly. However, if your total unpaid claims are less than $10, the claims are held and paid when the total exceeds $10. The $10 minimum does not apply, however, at the end of the plan year or subsequent 2½-month grace period and all claims will be paid to the extent of the balance in your dependent care spending account.

Claims for dependent care expenses during a plan year or during the 2½-month grace period ending on the 15th day of the third month (March 15) of the next plan year may be reimbursed out of your account balance for the year. If you terminate participation before the end of the plan year, the amount remaining in your account may continue to be applied toward the reimbursement of qualifying dependent care expenses incurred through the end of the plan year in which your participation terminated. If you continue to actively participate for the entire year and you submit a claim that was incurred during the grace period and you have an unused account balance for the plan year just ended, the reimbursement will be credited against that account balance first until it is exhausted before being credited against your account balance for the next plan year. This allocation will occur after the grace period ends, to provide you with the most beneficial use of your account.

All claims for reimbursement must be filed no later than 4½ months (May 15) after the end of the plan year. If you do not timely submit a claim, the claim will be denied. Any amount then remaining in your account will be forfeited (see the "Forfeitures" subsection).

Other Rules Regarding Your Flexible Spending Accounts

Termination of Participation

If you terminate employment or otherwise become an ineligible participant under the Flexible Benefits Plan, you will be ineligible to have any additional pay reductions credited to your medical spending account or dependent care spending account. If you have amounts remaining in your medical spending account or dependent care spending account, you may continue to turn in claims for reimbursement of expenses incurred before you terminate employment.

In addition, if the amount contributed to your medical spending account or dependent care spending account for the plan year exceeds the claims you have submitted for the plan year, you will generally be eligible to be reimbursed for claims incurred after you terminate employment.

If you participate in the medical spending account and you go on a military leave of absence, Employer will comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 with respect to the Plan. However, these requirements will only apply to the extent they provide you with more favorable coverage than under COBRA (i.e., coverage for a longer period of time or less costly coverage).

Forfeitures

Your pay reductions for each plan year may generally only be used to reimburse qualifying expenses incurred during that plan year. The only exception is that amounts in your medical and dependent care spending accounts at the end of a plan year may be used to reimburse qualifying medical and dependent care expenses incurred during the first 2½ months of the next plan year. An expense is "incurred" when the service is rendered or the supply is provided. However, see the special rule regarding orthodontia services in the last paragraph of the subsection entitled "Qualifying Medical Expenses."

Federal law requires the forfeiture of amounts remaining in your flexible spending accounts after expenses incurred during the plan year or the subsequent 2½-month grace period are reimbursed. A forfeiture will occur if you fail to use the entire amount in your medical spending account and dependent care spending account. You are not allowed to transfer unused amounts from one spending account to another spending account. You should be careful not to overestimate your expected expenses when you make your election. It is better to pay some of your expenses with after-tax income than to overestimate your expected expenses and have a forfeiture.

APPENDIX B – PLAN DOCUMENTS FROM THIRD PARTY PROVIDERS

Medical/Prescription and Dental
- Blue Cross Blue Shield

Vision
- VSP

Life Insurance and Accidental Death and Dismemberment (AD&D)
- The Standard

Long Term Disability
- The Standard

Short-term Disability (Union)
- The Standard

Supplemental Income Insurance
- Aflac

Member Handbook

Revised April 2018

Welcome

Thank you for choosing Blue Cross Blue Shield of Michigan. This Member Handbook will help you and your family get the most from your health plan. By being well-informed, you'll have the confidence and security of knowing that health care coverage is available when you need it.

This handbook gives an overview of your health care coverage. For more details about your coverage:

- Visit **bcbsm.com** and click *Login*
- Register to create an account

If you have technical difficulties, please call Web Support at **1-888-417-3479**.

To request a hard copy of this handbook, call the Customer Service number on the back of your Blue Cross member ID card.

The information in this handbook is a summary of your group's health care benefits. It's not a contract. It may not reflect additional limitations or exclusions that apply to covered services or the most recent updates to Blue Cross certificates, riders, plan modifications or changes that your group may be making to your coverage. Please contact your health care administrator or call the Customer Service phone number printed on the back of your member ID card if you have additional questions about your health care benefits.

Table of contents

Your Blue Cross member ID card

Once enrolled, you'll receive a Blue Cross member ID card. All cards will show the contract holder's name, even those issued to dependents.

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

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

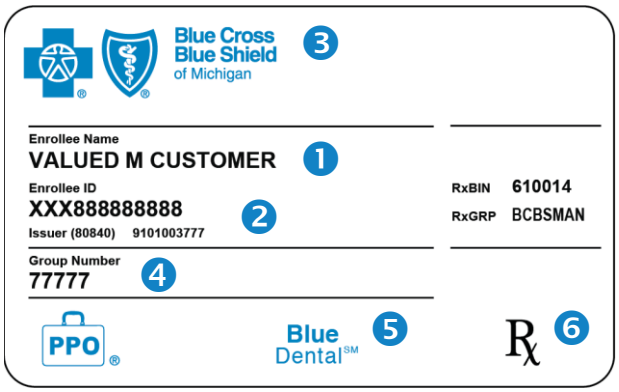
3 **Issuer:** Identifies you as a Michigan Blue Cross member to out-of-state providers

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

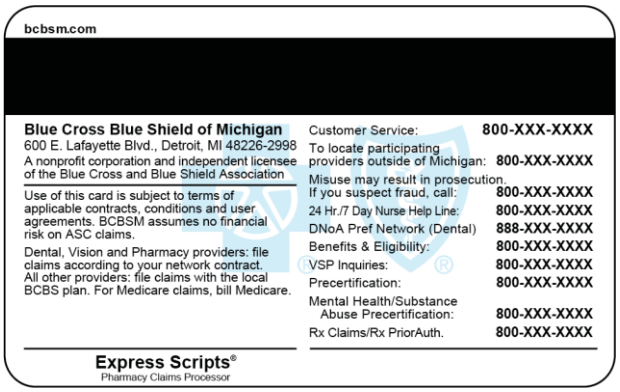
5 & **6** These icons are present if your coverage includes dental or prescription drugs

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

Sample card front



Sample card back



About your member ID card

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

Call us if your card is lost or stolen. Your provider can call us to verify coverage until you receive your new cards.

If you need additional ID cards:

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

You can also call the Customer Service number that is on the back of your ID card.

Mobile app and website

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

Here are some of our site and mobile app features:

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

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

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

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

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

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

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

How to create your online account

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

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

How to download the bcbsm.com mobile app

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

Member discounts with Blue365

Save money and live healthier with Blue365

Blue Cross members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States.

Member discounts with Blue365 offers exclusive deals on things like:

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

Cash in on discounts

Start saving today. Show your Blue Cross or Blue Care Network member ID card at participating local retailers or use an offer code online to take advantage of these savings. You can view all savings in one place through your member account at **bcbsm.com**.

For a full list of discount offers, log in or register at **bcbsm.com** and click *Member Discounts with Blue365* on the right side of your home page. You can also get monthly updates and details about new offers delivered directly to your email inbox. Just log in at **bcbsm.com** and opt-in to receive emails through *Paperless Options* under *Account Settings*.

Blue Cross Blue Shield Blue Care Network of Michigan

Blue365®

Because health is a big deal℠

Choosing your provider

Looking for a doctor, hospital or other health care professional?

You can choose any health care provider in your network for routine or general care. You don't need a referral for specialty or behavioral health care, and hospital services. To help narrow your options, visit **bcbsm.com** and click *Find a Doctor* to choose a health care provider who best matches your needs and maximize the value of your benefit plan. With this application you can:

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

You can also find a network provider for the following services on our site:

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

Approving covered services

Depending on the health care services you need, your provider might have to get prior approval. For more information and a list of services that need approvals, visit **bcbsm.com/importantinfo** and click on *approving covered services*.

What is a network provider?

A network provider is a physician, other health care specialist or hospital that provides services through our PPO network. PPO stands for preferred provider organization. PPO network providers have signed agreements with us to accept our approved amount as payment in full for services covered under your health care plan. Using PPO network providers limits your out-of-pocket costs for covered services to any deductible and copayments that may be required by your plan.

Special note for parents of students: Dependents attending school away from home still need to choose a physician in the PPO network. (See the section on BlueCard®.)

Limited network

Certain types of providers – including speech pathologists, nursing facilities and others – are not in our PPO network, but the services are paid at the in-network level. If you aren't sure if a health provider is considered in-network under your plan, please call the Customer Service number on the back of your Blue Cross member ID card.

What is an out-of-network provider?

An out-of-network provider is a physician, other health care specialist or hospital that hasn't signed an agreement to provide services through our PPO network. Your health care plan generally has higher out-of-pocket deductible and copays for services received outside the PPO network.

Important: Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible and copayment as payment-in-full for covered services.

Nonparticipating providers haven't signed an agreement and can bill you for any differences between their charges and our approved amount.

How providers are paid

How much you pay for services you receive depends on whether you use an in-network or out-of-network provider. We'll explain the difference below.

Under your health care program, the payment allowed for covered services is called our approved amount. This amount is the lower of the provider's billed charge or our maximum payment level for the covered service. Any deductible or copays required by your health care plan are subtracted from the approved amount before we make our payment.

PPO network providers — Blue Cross pays network providers directly. Because of their signed agreement with us, network providers accept this payment as payment in full for covered services. You're only responsible for in-network deductible or copays that may be required by your health care plan.

Choosing your provider

Out-of-network providers — If you go to a provider who isn't in our network, it's important to verify if the service is covered. Not all services outside the network are covered. Please call the Customer Service phone number on the back of your member ID card for verification of coverage.

When using out-of-network providers, you also need to find out if the provider participates with Blue Cross. Here's why this is important:

Participating providers — We pay participating providers directly. Because they have signed agreements with us, participating providers accept our payment as payment in full for covered services. You're responsible only for any out-of-network deductible or copays required by your health plan.

Nonparticipating providers — We send the payment directly to you, and it's your responsibility to pay the provider. Because our payment to you may be less than the provider's charge, you may also have to pay the difference between our payment and the provider's charge. This would be in addition to any out-of-network deductible or copays required by your health plan.

Nonparticipating hospitals, facilities and alternatives to hospital care providers — Our payment for services at nonparticipating hospitals is very limited and covers only those services required to treat accidental injuries or medical emergencies. This means that you'll need to pay most of the charges yourself, and your bill could be substantial. Please refer to your health care certificate for a complete explanation of your coverage when services are provided by a nonparticipating hospital or facility.

Preventing fraud

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

You can also help prevent fraud by checking your Explanation of Benefit Payments form. If you see a discrepancy on your EOB, contact your provider first to see if it's an error. If it's not and you believe it's fraudulent billing or use of your card, call our anti-fraud hot line at **1-800-482-3787**. You can also fill out our online Anti-Fraud form or write to:

Anti-Fraud Unit, Mail Code B759
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

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

Keeping your health information secure

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

- Visit **bcbsm.com/importantinfo**.
- Click on *Keeping your health information secure*.

What you pay out of pocket

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

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

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

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

Health resources

Blue Cross® Health & Wellness

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

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

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

To access the Blue Cross Health & Wellness website:

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

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

BlueCard® Program

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

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

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

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

Care away from home

Within the US

When you're traveling, you're covered through our **BlueCard℠** program. BlueCard gives Blue Cross members seamless national access to the 92 percent of physicians and 96 percent of hospitals that participate in Blue Cross networks. No matter where you live, work or travel, Blue Cross members, through BlueCard, can receive quality care. However, if the doctor or hospital is out of network, you could pay higher out-of-pocket costs.

To find a doctor or hospital outside of Michigan, you can use the *Find a Doctor* search tool at bcbsm.com**,** download and log on to our mobile app or call **1-800-810-2583**.

Outside the US

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

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

Making membership changes

Eligibility, enrollment and membership

You can also verify your Blue Cross membership records on our website when you log in to your account and click *Account Settings*.

Dependent coverage

Coverage for your dependents is based on the certificates and riders included in your health care plan. For dependent eligibility criteria, refer to your certificates and riders, which are available online. If you don't have online access, call the Customer Service phone number on the back of your member ID card.

Special enrollment periods

If you decline enrollment for yourself and your dependents (including your spouse) because of other health coverage, you may enroll in this plan later if:

- Your other coverage is terminated because of loss of eligibility or if employer contributions for the other coverage are terminated — provided that you request enrollment within 30 days after your other coverage or the contribution toward that coverage ends
- You have a new dependent because of marriage, birth, adoption or placement for adoption — provided you request enrollment within 31 days after the marriage, birth, adoption or placement of adoption

Note: Loss of eligibility includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It doesn’t include loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. If you decline enrollment because you had COBRA, or Consolidated Omnibus Budget Reconciliation Act continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan because of a loss of eligibility.

To request a special enrollment or obtain more information, please see your Human Resources department.

Promptly report the following changes to your employer. Your employer will notify Blue Cross Blue Shield of Michigan.

- Change of name or address — immediately
- Weddings — within 31 days of marriage
- New babies — within 31 days of birth
- Adoptions — within 31 days of the date of petition or the date of adoption
- Military service — within 30 days of induction or discharge
- 65th birthday — when you or your dependent become eligible for Medicare
- Children — contact your employer to verify eligibility for your children

Continuing coverage on your own

Your coverage will end for you and your dependents when you are no longer eligible through your employer group. However, you may continue temporary coverage through COBRA.

Please contact your Human Resources department for your coverage options and to find out eligibility dates.

Certificate of creditable coverage

The Health Insurance Portability and Accountability Act of 1996, or **HIPAA**, requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any exclusion periods for pre-existing conditions that might otherwise apply when changing coverage. When your coverage through your employer ends, you'll receive a certificate of creditable coverage. You also may request a certificate for health coverage periods on and after July 1, 1996, at any time during your coverage or within 24 months after loss of coverage. To request a certificate of creditable coverage, please call Blue Cross at **1-800-292-3501**.

Claims information

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

Filing a claim

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

If your provider won’t bill us for you, follow these steps:

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

Payments for services will be made directly to the health care contract holder.

Explanation of benefits

Your explanation of benefits

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

Receive your explanation of benefits electronically

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

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

Reading your EOB

Briefly, your explanation of benefits tells you:

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

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

What if my claim is rejected or denied?

Our goal is to process your claims correctly every time. If we deny your claim for benefits, you can appeal the denial of payment. For more information on the appeals process:

- Visit **bcbsm.com/importantinfo**
- Click *Appealing a claims decision*

EOB

Getting the care you need

Access to our staff

Blue Cross works with our network providers to make sure you're getting the highest quality care and service, and that you receive it promptly. This is called utilization management. If you have questions or want more information about this process, please call the Customer Service number on the back of your member ID card. TDD/TTY users start by dialing 711 or call **1-800-696-8350**. You must have a TTY/TDD device to use the TTY/TDD number.

Evaluating medical technology

Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan evaluate new technologies and the new applications of existing technologies to develop medical policies and make coverage recommendations. This process includes, but isn’t limited to, medical procedures and services, medical devices, surgical procedures, behavioral health procedures and pharmaceuticals.

Emergency care

If you're not sure whether your condition (such as high fever, sharp or unusual pain or minor injury) requires emergency care, but you think it needs prompt attention, it's best to call your doctor or your doctor's after-hours phone number.

You can also visit a network urgent care center for nonemergency conditions, such as earaches, colds, flu, minor burns, fever, sprains, sore throats and headaches. Visit **bcbsm.com** for a list of urgent care centers.

If you have an emergency and taking the time to call your doctor may mean permanent damage to your health, seek treatment first. Go to the nearest emergency room or call 911.

After the emergency has passed, your doctor can arrange appropriate follow-up care.

Some services aren't covered

Experimental treatment: We don’t pay for experimental treatment. Facility services and physician services, including diagnostic tests related to experimental procedures also aren’t payable. Please refer to your certificate for an explanation on how we determine experimental services. For a list of services not covered by your health plan:

- Log in at **bcbsm.com**
- Click *My Coverage*
- Click *Medical*
- Click *What's Covered* and scroll down to see what's not covered

Prescription drug coverage

If you have prescription drug coverage, visit **bcbsm.com/pharmacy** for detailed information about what your plan covers and the best way to use your prescription benefits. You can also find information about:

- Drugs covered under our pharmacy plans
- Mail order drug forms
- How to get approval for your medications (some drugs need approval, or prior authorization, or step therapy before your plan will cover them)
- Generic drug substitutions
- Quantity limits
- Preferred alternatives
- How to find a pharmacy
- Saving money on prescriptions
- How to request a review for coverage (if a drug isn't covered in your plan)
- Out-of-pocket expenses you pay for prescription drugs:
  - Visit **bcbsm.com** and log in
  - Click *My Coverage* and select *Prescription Drugs*
  - Click *What's Covered* — prescription drugs
- Do you need to speak to someone? Visit **bcbsm.com** and click on *Contact Us* at the top of the page and follow the instructions.

Coordination of benefits

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

If Blue Cross isn't your primary care provider, ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to Blue Cross.

Updating COB information is your responsibility

You can avoid claims-processing delays if you keep your COB information up to date. You can view your current COB information online.

If you need to change the information we have on record, notify your employer immediately. We may also periodically ask you to update your COB information.

For more information, visit **bcbsm.com/cob**.

Subrogation

Your contract with Blue Cross Blue Shield of Michigan includes a provision called "subrogation." If you file a lawsuit or an insurance claim, or if there is a settlement, subrogation allows Blue Cross Blue Shield of Michigan to hold a party that caused an injury or condition to be responsible for payment of the medical expenses related to the injury. For more information or for a copy of the form:

- Visit **bcbsm.com**
- Click *Help*
- Click *Popular Health Topics*
- Click *Other Topics*

Send us the completed form.

Mail: Blue Cross Blue Shield of Michigan
Subrogation Department
232 S. Capitol Ave., L09A
Lansing, MI 48933-1504

Email: **SubrogationUnit@bcbsm.com**

Phone: **1-866-296-3975**

Fax: **1-877-257-2012**

If you hire an attorney to represent you, have your attorney call Blue Cross at **1-866-296-3975**.

Customer service

To call us, please use the phone number printed on the back of your member ID card. You can also find this number on your EOB.

Our Customer Service hours are Monday through Friday from 8:30 a.m. to 5 p.m.

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

Our goal is to provide excellent service. When you call, please be ready to tell us your contract number. If you're inquiring about a claim, we'll also need the following information:

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

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

Language translation services

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

If you have a complaint

Blue Cross Blue Shield of Michigan and your primary care physician are interested in your satisfaction with the services you receive as a member. If you have a problem or concern about your care, we encourage you to discuss this with your primary care physician first. Most of the time, your primary care physician can correct the problem to your satisfaction. You're also welcome to call our Customer Service department with questions or concerns.

At any point during the complaint process, you may submit information or evidence to assist Blue Cross Blue Shield of Michigan in our investigation. You may file a complaint or appeal verbally or in writing. Complaints won't be accepted through email. There are no fees or costs associated with filing a complaint. All complaints can be submitted by calling Customer Service or via mail to the address listed below.

Customer Service: Use the phone number on the back of your Blue Cross Blue Shield of Michigan member ID card.

Mailing address:

Blue Cross Blue Shield of Michigan
Complaints — Mail Code 2004
600 E. Lafayette Blvd.
Detroit, MI 48226
Fax: 1-877-348-2210

We speak your language

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

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

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

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

ܐܢ ܐܚܬܘܢ، ܝܢ ܚܕ ܢܫܐ ܕܥܡ ܐܚܬܘܢ ܒܥܘܕܪܢܐ، ܣܢܝܩܐ ܝܠܗ ܥܘܕܪܢܐ، ܐܚܬܘܢ ܐܝܬܠܘܟ݂ܘܢ ܙܕܩܐ ܕܩܒܠܬܘܢ ܥܘܕܪܢܐ ܘܡܕܥܢܘܬܐ ܒܠܫܢܘܟ݂ܘܢ ܕܠܐ ܦܘܪܥܢܐ. ܠܡܡܠܘܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘ ܠܡܢܝܢܐ ܕܚܠܡܬ ܥܡܠܝܐ ܥܠ ܚܨܐ ܕܟܪܛܐ ܕܝܠܘܟ݂ܘܢ.

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

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

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

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন।

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

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

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

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

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

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

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

Important disclosure

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

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

Members rights and responsibilities

- Receive considerate and courteous care with respect for their privacy and human dignity.
- Candidly discuss appropriate, medically necessary treatment options for their health conditions, regardless of cost or benefit coverage.
- Participate with practitioners in decision making regarding their health care.
- Voice concerns or complaints about their health care by contacting Customer Service or submitting a formal written grievance through the Member Grievance program.
- Receive clear and understandable written information about Blue Care Network, its services, its practitioners and providers and their rights and responsibilities.
- Make recommendations regarding members' rights and responsibilities policies.
- Comply with the plans and instructions for care that they have agreed to with their practitioners.
- Provide, to the extent possible, complete and accurate information that Blue Care Network and its practitioners and providers need in order to provide care for them.
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals.

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

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ALBION COLLEGE
0070031570002 - 06MTX
Effective Date: 01/01/2018

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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

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

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

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

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

Eligibility Information

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse, same or opposite gender domestic partner eligible for coverage under the subscriber's contract • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship, including eligible children of your same or opposite gender domestic partner; eligible for coverage through the end of the calendar year in which they turn age 26.

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

Benefits	In-network	Out-of-network
Deductible	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **(no 4th quarter carry-over)** **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **(no 4th quarter carry-over)** **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations • $20 copay for chiropractic and osteopathic manipulative therapy • $50 copay for emergency room visits • $20 copay for urgent care visits	• $50 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year	$1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.

Benefits	In-network	Out-of-network
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

Benefits	In-network	Out-of-network
Routine and medically necessary mammogram and related reading - includes unilateral and bilateral digital breast tomosynthesis	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$20 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	80% after in-network deductible	60% after out-of-network deductible

Benefits	In-network	Out-of-network
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Online visits - by physician or **BCBSM** selected vendor must be medically necessary	$20 copay per online visit	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered

Benefits	In-network	Out-of-network
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Note: If your prescription is filled by any type of in-network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list, you do not need to pay the difference in cost between the maximum allowable cost and the BCBSM approved amount for the brand-name drug. You pay only your applicable copay.

Benefits	In-network pharmacy	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 2 - Preferred brand-name drugs	You pay $20 copay	You pay $20 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 3 - Nonpreferred brand-name drugs	You pay $40 copay	You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 90 day supply:** • You pay $10 copay for Tier 1 (generic) drugs • You pay $20 copay for Tier 2 (formulary brand) drugs • You pay $40 copay for Tier 3 (nonformulary brand) drugs	Not covered

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

Benefits	In-network pharmacy	Out-of-network pharmacy
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.

ALBION COLLEGE
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This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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

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

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

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

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

Eligibility Information

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse, same or opposite gender domestic partner eligible for coverage under the subscriber's contract • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship, including eligible children of your same or opposite gender domestic partner; eligible for coverage through the end of the calendar year in which they turn age 26.

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

Benefits	In-network	Out-of-network
Deductible	$1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations • $20 copay for chiropractic and osteopathic manipulative therapy • $50 copay for emergency room visits • $20 copay for urgent care visits	• $50 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year	$1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine and medically necessary mammogram and related reading - includes unilateral and bilateral digital breast tomosynthesis	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	

Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$20 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**

Benefits	In-network	Out-of-network
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Online visits - by physician or **BCBSM** selected vendor must be medically necessary	$20 copay per online visit	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits	In-network pharmacy	Out-of-network pharmacy
Generic or prescribed over-the-counter prescription drugs	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	You pay $40 copay	You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 90 day supply:** • You pay $10 copay for generic drugs • You pay $40 copay for brand name drugs	Not covered

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount

Benefits	In-network pharmacy	Out-of-network pharmacy
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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

Features of your prescription drug plan

Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Clinical Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.

Blue Cross Blue Shield of Michigan

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

ALBION COLLEGE
0070031570006 - 06FXL
Effective Date: 07/01/2017

Dental Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**
[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

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

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

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

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

Benefits	Coverage
Deductible • Applies to Class II and Class III services only	$100 per member limited to a maximum of $200 per family per calendar year
Class I services	10%
Class II services	10%
Class III services	50%
Class IV services	50%
Annual maximum for Class I, II and III services	$1,000 per member
Lifetime maximum for Class IV services	$1,000 per member

Class I services

Benefits	Coverage
Oral exams	90% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	90% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	90% of approved amount **Note:** Once every 36 months
Dental prophylaxis (teeth cleaning)	90% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	90% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	90% of approved amount
Fluoride treatments	90% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members under age 19	90% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	90% of approved amount after deductible **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	90% of approved amount after deductible **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	90% of approved amount after deductible **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	90% of approved amount after deductible **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery, except simply extractions	90% of approved amount after deductible
Root canal treatment - permanent tooth	90% of approved amount after deductible **Note:** Once every 12 months for tooth with one or more canals
Scaling and root planing	90% of approved amount after deductible **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	90% of approved amount after deductible **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	90% of approved amount after deductible **Note:** Once every 12 months
General anesthesia or IV sedation	90% of approved amount after deductible **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	90% of approved amount after deductible **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	90% of approved amount after deductible **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	90% of approved amount after deductible **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount after deductible **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount after deductible **Note:** Once every 60 months after original was delivered

Benefits	Coverage
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	Not covered

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

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

Get the best in eyecare and eyewear with ALBION COLLEGE and VSP® Vision Care.

VSP® Vision care for life

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Register at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.** To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

See why we're consumers' #1 choice in vision care[2].

Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

ALBION COLLEGE and VSP provide you with an affordable eyecare plan.

VSP Vision care for life

VSP Coverage Effective Date: 07/01/2015 **VSP Provider Network:** VSP Signature

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses		$25	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 allowance at Costco	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Scratch-resistant coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$0 $50 $80 - $90 $120 - $160	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam.....up to $50	Single Vision Lenses.....up to $50	Lined Trifocal Lenses.....up to $100	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $75	Progressive Lenses.....up to $75	

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195 | vsp.com**

[1] Brands/Promotion subject to change.
[2]Blueocean Market Intelligence National Vision Plan Member Research, 2014

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
Group Policy #163081
Effective Date March 1, 2017

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are an active Executive Staff, Faculty or Administrative employee of Albion College, a participating institution under the EIIA Higher Education Benefits Trust and regularly working at least 32 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 1 - Executive Staff, Faculty or Administrative Members earning $100,000 or more
Eligibility Waiting Period	You are eligible on the first of the month that follows the date you become a member.

Benefits

Basic Life Coverage Amount	2 times your annual earnings to a maximum of $1,000,000. Acceptable evidence of good health may be required to become insured for the amount of coverage in excess of $750,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.

Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Expanded AD&D Package
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, exclusions and when The Standard and Albion College, a participating institution under the EIIA Higher Education Benefits Trust may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279-D-MI-163081-C1 (5/17)
5254379-86630

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
Group Policy #163081
Effective Date March 1, 2017

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are an active facilities employee of Albion College, a participating institution under the EIIA Higher Education Benefits Trust subject to a collective bargaining agreement and regularly working at least 25 hours per week **OR** an active Secretarial or Clerical employee of Albion College subject to a collective bargaining agreement and regularly working at least 21 hours per week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 2 - Faculty or Administrative Members earning leass than $100,000, Facilities, Secretarial or Clerical Members subject to a collective bargaining agreement
Eligibility Waiting Period	You are eligible on the first of the month that follows the date you become a member.

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $50,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.

Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Expanded AD&D Package
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, exclusions and when The Standard and Albion College, a participating institution under the EIIA Higher Education Benefits Trust may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279-D-MI-163081-C2 (5/17)
5254379-86635

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
ASO #163081
Effective Date March 1, 2017

Group Short Term Disability Benefit Program

Group Short Term Disability (STD) benefit helps provide financial protection for covered members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this benefit plan is funded by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are a facilities employee of Albion College, a participating institution under the EIIA Higher Education Benefits Trust, actively working at least 25 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 1 - Facilities employees subject to a collective bargaining agreement working at least 25 hours per week
Eligibility Waiting Period	You are eligible on the first of the month that follows 120 consecutive days as a member.

Benefits

Weekly Benefit	60 percent of the first $500 of weekly predisability earnings as of the date of disability, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Weekly Benefit	$300
Minimum Weekly Benefit	$15
Benefit Waiting Period	Your weekly benefit becomes payable after you have been continuously disabled for 14 days for disability caused by accidental injury and after 14 days for disability caused by physical disease, pregnancy or mental disorder.

Definition of Disability	For the benefit waiting period and while the Short Term Disability benefits are payable, you are considered disabled if you: • Are unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation, or • Suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. You will no longer be considered disabled when your earnings from any occupation meet or exceed 80 percent of your predisability earnings.
Maximum Benefit Period	180 days

Other Features and Services

Albion College, a participating institution under the EIIA Higher Education Benefits Trust has retained Standard Insurance Company to act on its behalf as Claims Administrator for the Plan with respect to all claims for benefits submitted to The Standard for administration and management. The Standard shall receive, process, investigate and evaluate claims for benefits. The Standard has authority to make initial decisions to approve, deny or close claims for benefits. The Standard is also authorized to review and decide appeals of denied or closed claims, if requested by claimants as provided in the appeal provision of the Plan. Thereafter, Albion College, a participating institution under the EIIA Higher Education Benefits Trust may elect to hear and decide any further appeals by claimants. In each case, Albion College, a participating institution under the EIIA Higher Education Benefits Trust retains the right of final review and decision on all claims and appeals.

The Standard will also perform certain administrative services for the Plan, including advising and assisting Albion College, a participating institution under the EIIA Higher Education Benefits Trust with preparation and revision of the Plan and providing actuarial services. The Standard has no authority or obligation with respect to management or investment of the assets of the Plan or Albion College, a participating institution under the EIIA Higher Education Benefits Trust right of subrogation under the Plan.

This information is only a brief description of the STD benefit plan provided by Albion College, a participating institution under the EIIA Higher Education Benefits Trust and administered by Standard Insurance Company. The controlling provisions will be in the Plan Document adopted by the Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The Plan Document contains a detailed description of the limitations, reductions in benefits, and exclusions. The Plan Document that describes the terms and conditions of the coverage is available for those who become covered according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 14903-D-MI-163081-C1 (3/17)
5254475-86649

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
ASO #163081
Effective Date March 1, 2017

Group Short Term Disability Benefit Program

Group Short Term Disability (STD) benefit helps provide financial protection for covered members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this benefit plan is funded by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are a secretarial or clerical employee of Albion College, a participating institution under the EIIA Higher Education Benefits Trust, subject to a collective bargaining agreement, actively working at least 21 hours per week but less than 35 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 3 - Secretarial and Clerical Employees subject to a collective bargaining agreement working at least 21 hours per week but less than 35 hours per week
Eligibility Waiting Period	You are eligible on the first of the month that follows 120 consecutive days as a member.

Benefits

Weekly Benefit	60 percent of the first $300 of weekly predisability earnings as of the date of disability, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Weekly Benefit	$180
Minimum Weekly Benefit	$15
Benefit Waiting Period	Your weekly benefit becomes payable after you have been continuously disabled for 14 days for disability caused by accidental injury and after 14 days for disability caused by physical disease, pregnancy or mental disorder.

Definition of Disability	For the benefit waiting period and while the Short Term Disability benefits are payable, you are considered disabled if you: • Are unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation, or • Suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. You will no longer be considered disabled when your earnings from any occupation meet or exceed 80 percent of your predisability earnings.
Maximum Benefit Period	180 days

Other Features and Services

Albion College, a participating institution under the EIIA Higher Education Benefits Trust has retained Standard Insurance Company to act on its behalf as Claims Administrator for the Plan with respect to all claims for benefits submitted to The Standard for administration and management. The Standard shall receive, process, investigate and evaluate claims for benefits. The Standard has authority to make initial decisions to approve, deny or close claims for benefits. The Standard is also authorized to review and decide appeals of denied or closed claims, if requested by claimants as provided in the appeal provision of the Plan. Thereafter, Albion College, a participating institution under the EIIA Higher Education Benefits Trust may elect to hear and decide any further appeals by claimants. In each case, Albion College, a participating institution under the EIIA Higher Education Benefits Trust retains the right of final review and decision on all claims and appeals.

The Standard will also perform certain administrative services for the Plan, including advising and assisting Albion College, a participating institution under the EIIA Higher Education Benefits Trust with preparation and revision of the Plan and providing actuarial services. The Standard has no authority or obligation with respect to management or investment of the assets of the Plan or Albion College, a participating institution under the EIIA Higher Education Benefits Trust right of subrogation under the Plan.

This information is only a brief description of the STD benefit plan provided by Albion College, a participating institution under the EIIA Higher Education Benefits Trust and administered by Standard Insurance Company. The controlling provisions will be in the Plan Document adopted by the Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The Plan Document contains a detailed description of the limitations, reductions in benefits, and exclusions. The Plan Document that describes the terms and conditions of the coverage is available for those who become covered according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

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5256280-86821

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
ASO #163081
Effective Date March 1, 2017

Group Short Term Disability Benefit Program

Group Short Term Disability (STD) benefit helps provide financial protection for covered members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this benefit plan is funded by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are a secretarial or clerical employee of Albion College, a participating institution under the EIIA Higher Education Benefits Trust, subject to a collective bargaining agreement, actively working at least 35 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 2 - Secretarial and Clerical Employees subject to a collective bargaining agreement working at least 35 hours per week
Eligibility Waiting Period	You are eligible on the first of the month that follows 120 consecutive days as a member.

Benefits

Weekly Benefit	60 percent of the first $500 of weekly predisability earnings as of the date of disability, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Weekly Benefit	$300
Minimum Weekly Benefit	$15
Benefit Waiting Period	Your weekly benefit becomes payable after you have been continuously disabled for 14 days for disability caused by accidental injury and after 14 days for disability caused by physical disease, pregnancy or mental disorder.

Definition of Disability	For the benefit waiting period and while the Short Term Disability benefits are payable, you are considered disabled if you: • Are unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation, or • Suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. You will no longer be considered disabled when your earnings from any occupation meet or exceed 80 percent of your predisability earnings.
Maximum Benefit Period	180 days

Other Features and Services

Albion College, a participating institution under the EIIA Higher Education Benefits Trust has retained Standard Insurance Company to act on its behalf as Claims Administrator for the Plan with respect to all claims for benefits submitted to The Standard for administration and management. The Standard shall receive, process, investigate and evaluate claims for benefits. The Standard has authority to make initial decisions to approve, deny or close claims for benefits. The Standard is also authorized to review and decide appeals of denied or closed claims, if requested by claimants as provided in the appeal provision of the Plan. Thereafter, Albion College, a participating institution under the EIIA Higher Education Benefits Trust may elect to hear and decide any further appeals by claimants. In each case, Albion College, a participating institution under the EIIA Higher Education Benefits Trust retains the right of final review and decision on all claims and appeals.

The Standard will also perform certain administrative services for the Plan, including advising and assisting Albion College, a participating institution under the EIIA Higher Education Benefits Trust with preparation and revision of the Plan and providing actuarial services. The Standard has no authority or obligation with respect to management or investment of the assets of the Plan or Albion College, a participating institution under the EIIA Higher Education Benefits Trust right of subrogation under the Plan.

This information is only a brief description of the STD benefit plan provided by Albion College, a participating institution under the EIIA Higher Education Benefits Trust and administered by Standard Insurance Company. The controlling provisions will be in the Plan Document adopted by the Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The Plan Document contains a detailed description of the limitations, reductions in benefits, and exclusions. The Plan Document that describes the terms and conditions of the coverage is available for those who become covered according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

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5256280-86820

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
Group Policy #163081
Effective Date March 1, 2017

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are a regular Executive Staff, Faculty or Administrative employee of Albion College, a participating institution under the EIIA Higher Education Benefits Trust, actively working at least 32 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 1 - Executive Staff, Faculty and Administrative Members earning $100,000 or more
Eligibility Waiting Period	You are eligible on the first day that follows 12 consecutive months as a member.

Benefits

Monthly Benefit	60 percent of the first $25,000 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$15,000
Minimum Monthly Benefit	$100 or 10 percent of the Long Term Disability benefit before reduction by deductible income, whichever is greater
Benefit Waiting Period	180 days

Definition of Disability	For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder: • You are unable to perform with reasonable continuity the material duties of your own occupation, or • You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation. You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.
Maximum Benefit Period	If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins: **Age** — **Maximum Benefit Period** 62 — 3 years 6 months 63 — 3 years 64 — 2 years 6 months 65 — 2 years 66 — 1 year 9 months 67 — 1 year 6 months 68 — 1 year 3 months 69+ — 1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Annuity Contribution Benefit
- Assisted Living Benefit
- Conversion of Insurance Provision
- Employee Assistance Program
- Family Care Expense Adjustment
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Albion College, a participating institution under the EIIA Higher Education Benefits Trust may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

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5254379-86631

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
Group Policy #163081
Effective Date March 1, 2017

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are a regular Faculty or Adminstrative employee of Albion College, a participating institution under the EIIA Higher Education Benefits Trust, actively working at least 32 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 2 - Faculty and Administrative Members earning less than $100,000
Eligibility Waiting Period	You are eligible on the first day that follows 12 consecutive months as a member.

Benefits

Monthly Benefit	60 percent of the first $12,500 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$7,500
Minimum Monthly Benefit	$100 or 10 percent of the Long Term Disability benefit before reduction by deductible income, whichever is greater
Benefit Waiting Period	180 days

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, or
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Annuity Contribution Benefit
- Assisted Living Benefit
- Conversion of Insurance Provision
- Employee Assistance Program
- Family Care Expense Adjustment
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Albion College, a participating institution under the EIIA Higher Education Benefits Trust may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

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1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

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5254379-86633

Standard Insurance Company
Albion College, a participating institution under the EIIA Higher Education Benefits Trust
Group Policy #163081
Effective Date March 1, 2017

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by Albion College, a participating institution under the EIIA Higher Education Benefits Trust.

Eligibility

Definition of a Member	You are a member if you are a regular Facilities employee subject to a collective bargaining agree of Albion College, a participating institution under the EIIA Higher Education Benefits Trust, actively working at least 25 hours per week, and a citizen or resident of the United States or Canada **OR** a regular Secretarial or Clerical employee subject to a collective bargaining agreement of Albion College, a participating institution under the EIIA Higher Education Benefits Trust, actively working at least 21 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 3 - Facilities, Secretarial and Clerical Members subject to a collective bargaining agreement
Eligibility Waiting Period	You are eligible on the first day that follows 12 consecutive months as a member.

Benefits

Monthly Benefit	60 percent of the first $12,500 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$7,500
Minimum Monthly Benefit	$100 or 10 percent of the Long Term Disability benefit before reduction by deductible income, whichever is greater
Benefit Waiting Period	180 days

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, or
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Annuity Contribution Benefit
- Assisted Living Benefit
- Conversion of Insurance Provision
- Employee Assistance Program
- Family Care Expense Adjustment
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by Albion College, a participating institution under the EIIA Higher Education Benefits Trust. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Albion College, a participating institution under the EIIA Higher Education Benefits Trust may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

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