PLAN DESCRIPTION

CONSOLIDATED BENEFIT TRUST "CBT"

HEALTHCARE PLAN OF

BENEFITS

MOTT COMMUNITY COLLEGE

Revised June 23, 2009

Benefits Insured by Associated Mutual Insurance Company

5800 Foremost Drive, S.E.
Grand Rapids. Michigan 49546
(888) 808-0408

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CBT PUBLIC EMPLOYER HEALTH CARE PLAN

HEALTH CARE BENEFITS PLAN

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IMPORTANT NOTICE: Federal law requires every employer to notify each covered employee and dependent(s) of their rights for Continuation of Coverage after termination of employment. Your rights regarding Continuation of Coverage can be found in Section VIII of this booklet.

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INTRODUCTION TO THIS PLAN DESCRIPTION

TO OUR COVERED EMPLOYEES AND DEPENDENTS:

We are pleased to provide you with this plan description of your Consolidated Benefit Trust (CBT) Healthcare Plan of Benefits ("the Plan"). As you read this booklet, keep in mind that it is intended to be a simple summary of the terms and conditions of benefits and coverage. Although this booklet describes in general terms the eligibility and coverage under the Plan, it is not intended to cover every situation which might occur. This Plan Description is not a substitute for the Plan itself, which consists of the official insurance policies insuring the Trust which are issued by Associated Mutual or any other insurer so designated by CBT under this Plan, as well as other documents and agreements with administrators.

Any reference in this booklet to coverage(s) not shown in the Benefits Coverage Schedule(s) shall not be applicable. The terms and conditions for eligibility and coverage are contained in this Plan Description booklet.

All CBT Fund benefits are insured by Associated Mutual Life Insurance Company ("Associated Mutual"). The Consolidated Benefit Trust Fund (CBT) has retained Aetna to provide administrative services with respect to medical benefits to covered participants of the Fund. Aetna administers the CBT Benefit Plans according to CBT specifications and assumes no insurance liability regarding the benefits provided. The CBT also contracts with Caremark as the preferred Pharmaceutical Benefit Manager (PBM). Caremark as well does not assume any insurance liability on any CBT medical plan. CBT and not Associated Mutual, Aetna or Caremark, is responsible for the content of this Plan Description.

The actual administration of benefits under this Plan is handled by several entities. Please use your Aetna Identification Card (ID card) when receiving treatment from your doctor and/or hospital. Aetna is the Claims Administrator and will also process your medical claim. Caremark RX is the prescription drug benefit program manager. BPA is the Plan Administrator that provides all billing, employee eligibility, and claims customer service functions. Even though there are a number of entities handling your benefits, your physician will only need to file one claim, and only with Aetna.

You should direct all of your claim inquiries to BPA at (616) 808-2898 or (800) 370-4349. Please note that only BPA is authorized to answer your questions or provide information regarding the Plan, and any claim or benefits under the Plan.

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

The Trust Agreement and insurance policies under which this Plan Description is issued may be amended or discontinued at any time by the Board of Trustees of CBT.

Best Regards,

Consolidated Benefit Trust Fund Trustees

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SECTION I

IMPORTANT DEFINITIONS AND TERMS

The following terms are used throughout this booklet:

1.01 The term **"Accidental Injury"** shall mean any physical damage caused by an action, object or substance outside the body. This includes: strains, sprains, cuts, and bruises - allergic reactions caused by an outside force such as bee stings or other insect bites - frostbite, sunburn, sunstroke - swallowing poisons -drug overdosing - inhaling smoke, carbon monoxide, or fumes.

1.02 The term **"Actively At Work"** shall mean a Member/Employee must be on the job and physically able (other than absences due to a medical condition or medical treatment) to perform his/her regular full time duties for a regularly scheduled workday. The number of hours which must be worked per week, if any, in order to meet the Actively At Work requirement is shown in the Employer Data Schedule located in Appendix C.

1.03 The Term **"Aetna"** shall mean Aetna Insurance Company of America.

1.04 The term "**Approved Amount**" shall mean the maximum payment level or the provider's billed charge for the covered service, whichever is lower. Any required deductibles and copays are deducted from the approved amount.

1.05 The term "**Approved Facility**" shall mean a hospital or clinic that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care or physical therapy. Approved facilities must meet all applicable local and state licensing and certification requirements. These facilities have entered into agreements with Aetna to provide these services.

1.06 The term "**Associated Mutual"** shall mean Associated Mutual Insurance Company, health care insurer of the CBT located at 5800 Foremost Drive S.E., Grand Rapids, Michigan 49546. Telephone number (616) 808-2898.

1.07 The term **"Administrator"** shall mean either BPA or Aetna, depending on the function. Benefit Plan Administrators of Michigan, Inc. ("BPA"), 5800 Foremost Drive S.E., Grand Rapids Michigan 49546 (telephone number: (616) 808-2898) or (800) 370-4349 has been designated by CBT as the "Plan Administrator" and handles Member eligibility and customer service, such as providing Members with information and responding to inquiries regarding claims. Aetna is the "Claims Administrator" and is responsible for processing the claims filed by your health care provider.

1.08 The term "**Benefit Plan Administrators (BPA)"** shall mean the licensed Third Party Administrator (TPA) retained by the Consolidated Benefit Trust to provide certain third party services such as; billing, employee maintenance, customer service, etc. You should direct any questions concerning your coverage and benefits under this Plan to Benefit Plan Administrators (BPA): 5800 Foremost Drive, S.E., Suite #207, Grand Rapids, Michigan 49546 Telephone number(s): (800) 370-4349.

1.09 The term **"Benefit Year"** or **"Benefit Period"** shall mean the period beginning January 1, and ending on December 31, each year. Any, and all, eligible expenses incurred by a Covered Member during a Benefit Year will be subject to the Plan Maximum benefit.

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1.10 The term **"CBT"** shall mean Consolidated Benefit Trust, a Voluntary Employee Beneficiary Association (VEBA).

1.11 The term **"Copayment"** shall mean the designated portion of the approved amount you are required to pay for covered services. This can be either a fixed dollar or percentage amount.

1.12 The term **"Covered Services"** shall mean the services, treatments, or supplies identified as payable in the Plan. Covered services must be medically necessary to be payable, unless stated otherwise.

1.13 The term "**Creditable Coverage"** shall mean a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

1.14 The term **"Deductible "** shall mean the amount of out-of-pocket expense incurred during each Benefit Period by the Member to satisfy the individual or family Deductible specified in Appendix "A", Schedule of Benefits) before payment will begin for covered services. Only services covered under this Plan may be applied toward the Deductible.

NOTE: Copayments, as defined in 1.11, are not applied toward your annual deductible or the annual out of pocket maximum, as defined in 1.40.

* **Carry-Over Provision** - Eligible expenses incurred and applied toward your Deductible during the last three months of any calendar year, will be applied toward the following year's Deductible.

1.15 The term **"Dependent"** shall mean an employee Member's dependent spouse while not divorced or legally separated from the employee Member; and each of the employee Member's unmarried dependent children for whom the member can claim as dependents. Dependent eligibility and limiting age of dependents is defined in Section II of this document. An employee Member's child(ren) shall include stepchildren, legally adopted children, and any other children receiving coverage pursuant to a Qualified Medical Child Support Order.

1.16 The term "**Designated Facility**" shall mean a facility that the Plan determines to be qualified to perform certain procedures.

1.17 The term **"Doctor"**, **"Provider"** or **"Legally Qualified Physician"** shall mean a physician licensed to practice medicine and perform surgery. Not withstanding the foregoing, benefits shall not be denied under the Plan solely because charges are for medical care or services which are not provided by a legally qualified physician, so long as such care or services are provided by a person qualified as a licensed, consulting psychologist and may legally be so provided or they are provided by a person licensed to practice chiropractic medicine, optometry, or podiatry acting within the scope of his/her license.

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1.18 The term **"Effective Date"** shall mean this Plan's effective date. A Member's "Effective Date" shall be that date this Plan's benefits became effective for that Member.

1.19 The term **"Eligible Charges"** shall mean charges, subject to any limitations or exceptions provided in this Plan actually made to the Member for the eligible treatment or services to the extent that such charges are within the Usual, Customary, and Reasonable Fee Schedule established by the Plan.

1.20 The term "**Emergency First Aid**" shall mean the initial exam and treatment of conditions resulting from accidental injury.

1.21 The term **"Employer"** shall mean the Employer listed on the Employer Data Schedule located as Appendix "C" of this booklet.

1.22 The term **"Experimental"** and/or **"Investigational"** shall mean a service, procedure, treatment, device, or supply which has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. The Plan will make this determination based on a review of established criteria. We do not cover experimental or investigational drugs or services. Facility services and physician services, including diagnostic tests, which are related to experimental or investigational procedures, are also not covered. A service may be determined to be experimental or investigational when there is:

- ✓ A written experimental or investigational plan by the attending provider or another provider studying the same service, or
- ✓ A written informed consent used by the treating provider in which the service is referred to as experimental, investigational or other than conventional or standard therapy, or
- ✓ An on-going clinical trial.

The following information will be used in the evaluation process:

- ✓ Scientific data such as controlled studies in peer review journals or medical literature
- ✓ Information from Health Care Associations or other local or national bodies
- ✓ Information from local and national medical societies, other appropriate professional societies, organizations, committees or governmental bodies
- ✓ Approval, when applicable, by the Food and Drug Administration, the Office of Health Technology Association and other governmental agencies
- ✓ Accepted national standards of practice in the medical profession
- ✓ Approval by the Institutional review Board of the hospital or medical center

1.23 The term **"Extended Care Facility"** shall mean an institution or a distinct part of an institution which is primarily engaged in providing, for a fee, room and board and skilled nursing care and related services and which meets each of the following requirements: (1) is primarily engaged in providing skilled nursing care and related services for persons convalescing from sickness and injury under twenty-four (24) hour supervision of a legally qualified physician or a registered graduate nurse, (2) has the services of a legally qualified physician available at all times, (3) has such other nursing personnel as may be necessary to provide continuous care of patients, (4) requires each patient be under the care of a legally qualified physician, (5) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals, (6) maintains a daily clinical record for each patient, (7) complies with all licensing and other legal requirements and (8) must be recognized and approved as an Extended Care Facility by Blue Cross Blue Shield of Michigan. However, in no event shall such term include an institution or part thereof which is used primarily as a rest facility, or a facility for the care and treatment of mental diseases or tuberculosis, or for the aged, blind, or the deaf, or for the care of drug addicts or alcoholics, or a facility of

custodial or educational care.

1.24 The term **"Home Health Agency"** shall mean a public or private agency or organization, or a sub-division thereof, that (1) is primarily engaged in providing skilled nursing and other therapeutic services, (2) has policies established by associated professional personnel, including one or more legally qualified physicians and one or more registered graduate nurses to govern the services provided under the supervision of such a physician or nurse, (3) maintain clinical records on all patients, (4) in cases where state and local law provides for the licensing of agencies or organizations of this nature, the latter is licensed or approved by the state or local law as meeting the standards established for such licensing, and (5) must be recognized and approved as a Home Health Care Agency by Aetna. In no event will the term "home health agency" include one which is engaged primarily in the care and treatment of mental disease or disorder.

1.25 The term **"Hospice Care"** shall mean care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

1.26 The term **"Hospice Care Program"** shall mean a written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

1.27 The term **"Hospital"**, or **"Facility"** shall mean (1) An institution for the care and treatment of sick and injured persons which is under the supervision of a medical staff of legally qualified physicians and has organized facilities for diagnosis, treatment, major surgery, and twenty-four (24) hour nursing services by registered graduate nurses, or (2) An institution for the treatment of tuberculosis (exclusively) which is under the supervision of a medical staff of legally qualified physicians and has twenty-four hour nursing service by registered graduate nurses, or (3) An institution for the treatment of mental diseases and disorders (exclusively) -- other than an institution the primary function of which is custodial and not therapeutic -- which is under the supervision of a medical staff of legally qualified physicians and has twenty-four (24) hour nursing service by registered graduate nurses. A Hospital must be recognized and approved as a Hospital or Facility by Aetna. Non-participating facilities are generally paid at levels lower than the actual charges being made to the patient.

1.28 The term **"Illness"** shall mean a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

1.29 The term "**In-Network Services**" shall mean services performed or referred by a Network Provider.

1.30 The term **"In-Patient"** shall mean a covered Member who is confined in a hospital as a bed patient for whom a room and board charge is made by the hospital.

1.31 The term **"Health Care Pool"** shall mean the CBT pool of public employees for health care and other medical care coverages.

1.32 The term "**Medical Necessity**" or **"Medically Necessary**" shall mean the medical necessity for payment of covered hospital services including all of the following:

- The service is for the treatment, diagnosis or symptoms or an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the

diagnosis.

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigative.

Medical necessity is based on criteria and guidelines developed by Aetna. Medical necessity for payment of covered physician services includes all of the following:

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the patient or physician.
- In the case of diagnostic testing, the results are essential to and are used in the diagnosis and management of the patient's condition.

1.33 The term **"Member"**, **"Covered Member"** or **"Employee Member"** shall mean an employee who has met the eligibility requirements for coverage under the Plan; "Member" shall also mean, where applicable, a Dependent covered under the Plan by virtue of a relationship to an employee Member. An independent contractor is not considered an employee member.

1.34 The term **"Network Provider"** shall mean a health care provider who has contracted to furnish services or supplies for a negotiated charge; but only if the provider is, with Aetna's consent, included in the directory as a network provider for:

- The service or supply involved; and
- The class of employees to which you belong.

1.35 The term **"Non-Specialist"** shall mean a physician who is not a specialist.

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

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

1.37 The term **"Operation"** shall mean a surgical procedure involving one of the following: cutting, repair, suturing, electro cauterization, removal of stone or foreign body by endoscopic means or injection of sclerosing solution.

1.38 The term "**Out-of-Network Services**" shall mean services not performed or referred by a Network Provider.

1.39 The term **"Out-of-Network Provider"** shall mean a health care provider who has not contracted with Aetna to furnish services or supplies at a negotiated charge.

1.40 The term "**Out of Pocket Maximum**" shall mean the predetermined amount a Member must pay in a benefit year before the Plan covers all remaining medical services at 100% excluding mental health, substance abuse, private duty nursing, and any office and emergency room copayments. Please refer to the Schedule of Benefits for the Out of Pocket Maximum amount.

1.41 The term **"Participating Facility"** shall mean a health care facility which participates with Aetna. They will bill the Plan directly and you pay only for services not covered under this Plan and for required co-

payments and deductibles.

1.42 The term "**Participating Provider**" is a professional provider who has signed an agreement with Aetna. They will receive direct payment. You will be billed only for services not covered under the Plan and for required co-payments and deductibles.

1.43 The term "**Non-Participating Provider**" is a professional provider who has not signed an agreement with Aetna, and may or may not accept the Plan payment as full reimbursement. The Member may be responsible for an amount greater than the allowable Plan payment.

1.44 The term **"Preferred (In-Network) Provider"** shall mean hospitals, physicians and other licensed facilities or health care professionals selected by Aetna to provide services.

1.45 The term **"Participating Facility"** shall mean a health care facility which participates with Aetna. You pay only for services not covered under this plan and for required co-payments and deductibles.

1.46 The term **"Payment Percentage"** shall mean the percentage of covered expenses that the plan pays, and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the "plan payment percentage," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on payment percentage amounts.

1.47 The term **"Plan"** shall mean this CBT Health Plan of Medical Care Benefits provided through Associated Mutual, Aetna Joint Claims Administration (JCA) Program, and Benefit Plan Administrators of Michigan.

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

(a) Group coverage or any other insured or uninsured arrangement of coverage for which any employer contributes all or part of the cost, and/or makes payroll deductions; or

(b) Basic automobile reparation (no-fault) coverage, but only to the extent of the benefits required by, or available under the applicable no-fault law, and if such no-fault coverage does not, under its rules, determine its benefits after the benefits of any group health, dental, and/or vision coverage.

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

1.48 The term **"Plan Year"** shall mean that twelve-month period over which billing and claims records are maintained and utilized for filing government 5500 forms.

1.49 The Term **"PPO"** shall mean Aetna's Preferred Provider Organization PPO medical plan which provides coverage for a wide range of medical expenses for the treatment of illness or injury. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. This PPO plan is designed to lower your out-of-pocket costs when you use network providers for covered expenses. Your deductibles, copayments, and coinsurance will generally be lower when you use participating network providers and facilities.

1.50 The term **"PPO Directory"** shall mean a listing of all network providers serving the class of employees which you belong. A copy of the directory is available through Aetna. Network provider information is also available through Aetna's online provider directory, "DocFind" located on their website at www.aetna.com/docfind.

1.51 The term **"Precertification" or "Precertify"** shall mean a process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are

prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

1.52 The term "**Prescription"** shall mean an order for the dispensing of a prescription drug by a prescriber. If it is an oral order, it must be promptly put in writing by the pharmacy.

1.53 The term "**Prescription Drug"** shall mean a drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

1.54 The term "**Prescription Drug Benefit Manager"** (BPM) shall mean CVS Caremark.

1.55 The term **"Recognized Charge"** shall mean that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
  a) For non-facility charges: Aetna uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
  b) For facility charges: Aetna uses the charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished

1.56 The term "**Routine Service**" shall mean procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.

1.57 The term "**Screening Services**" shall mean the procedures or tests that are ordered that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a routine physical are considered screening.

1.58 The term **"Service Requirement"** shall mean the amount of continuous employed time an employee must be in active employment in a covered classification with the Employer before the employee can become eligible for coverage under this Plan. The Service Requirement for this group is listed in the Employer Data Schedule located in Appendix C.

1.59 The term "**Substance Abuse**" shall mean the taking of alcohol or other drugs in amounts that can:

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

1.60 The term **"Surgery Center"** shall mean a freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.

- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - ✓ Physicians who practice surgery in an area hospital; and
  - ✓ Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.
- Must have all of the following:
- A physician trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

1.61 The term **"Therapy"** shall mean Physical, Occupational, and Speech Therapy. Such therapy may be provided in the inpatient or outpatient departments of an approved, participating hospital, an approved outpatient physical therapy facility, doctor's office, or an independent physical therapist.

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

Occupational therapy means treatment consisting of specifically designed therapeutic tasks or activities which: improve or restore a patient's functional level when there has been a loss in the function of muscles or joints due to illness or injury; and, help the patient learn to apply the newly-restored or improved function to meeting the demands of daily living. To be payable, occupational therapy must be: prescribed by a patient's attending physician; provided by or under the supervision of a physician or a licensed occupational therapist; and, provided for a condition with the potential for significant improvement in a reasonable and generally predictable period of time. A rehabilitative service must include and use specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

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

Speech therapy means active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery. Speech therapy is covered when it is part of a rehabilitation program and is part of the physical therapy benefit. To be payable, speech therapy must be: referred by the attending physician;

given by a certified speech pathologist, and, provided for a condition expected to be significantly improved in a reasonable period of time.

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

Examples of therapy not covered under this plan: long-standing, chronic conditions; developmental conditions or learning disabilities; congenital or inherited speech abnormalities; and, inpatient hospital admissions principally for speech or language therapy.

1.62 The term **"Urgent Admission"** shall mean a hospital admission by a physician due to:

- The onset of or change in a illness; or
- The diagnosis of a illness; or
- An injury.
- The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

1.63 The term **"Urgent Care Provider"** shall mean:

- A freestanding medical facility that meets all of the following requirements.
  - ✓ Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - ✓ Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - ✓ Makes charges.
  - ✓ Is licensed and certified as required by any state or federal law or regulation.
  - ✓ Keeps a medical record on each patient.
  - ✓ Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - ✓ Is run by a staff of physicians. At least one physician must be on call at all times.
  - ✓ Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
  - ✓ Has contracted with Aetna to provide urgent care; and
  - ✓ Is, with Aetna's consent, included in the directory as a network urgent care provider.
- It is not the emergency room or outpatient department of a hospital.

1.64 The term "**Urgent Condition"** shall mean the onset of a sudden illness; injury; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

1.65 The term "**Walk-in Clinic"** shall mean a network of free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.

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1.66 The term **"Web Based Tools**" means a variety of customer service options that are available to the covered member via the internet. Aetna's internet home page at www.aetna.com provides a number of resources for Members.

SECTION II

ELIGIBILITY FOR COVERAGE

2.01 Initial Employee Eligibility

It is important for you to review Appendix "C", Employer Data Schedule, found at the end of this booklet. To determine if you are eligible for coverage under this Plan, be sure to review all sections, but in particular Eligible Class, Service Requirement, and Employee Contribution sections of that Schedule.

(a) **In cases where the Employer pays the full cost of coverage,** an employee shall be eligible for coverage as a Member under the Plan provided he meets all of the following conditions:

(i) The Plan is in effect for his/her Employer; and

(ii) The employee is included in a class of employees which is eligible for coverage under the Plan; and

(iii) The employee is Actively At Work and meets any applicable minimum hours per week requirement; and

(iv) The employee has satisfied the applicable Service Requirement.

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

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

Employees who do not complete a written enrollment and authorization for payroll deduction within thirty-one (31) days after the date of initial eligibility (as defined in paragraph (a) above) may not enroll for coverage in the Plan until the next following Open Enrollment or succeeding Open Enrollments thereafter except for family changes as provided in Section 2.04 below.

2.02 Effective Date of Coverage

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

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

IMPORTANT NOTE: The Benefit Administrator must have received a completed employee enrollment form within thirty-one (31) days of initial eligibility date for coverage. Prior to the payment of any claims, BPA, the Plan Administrator, must have received a completed enrollment form for the covered member.

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2.03 Dependent Eligibility

(a) If an employee Member is included in a class of employees for which dependent coverage applies, eligible Dependents (as defined in Section1.15) of that employee shall, on the date the employee becomes a Member, become covered Members under the Plan, effective as of the date the employee becomes a covered Member under the Plan provided the Dependent is not hospitalized on that date. Should a Dependent be hospitalized on the employee Member's effective date of coverage, coverage will be effective on the date the Dependent has been released from the hospital and is able to perform his/her normal duties.

(b) An employee Member's Dependent Child(ren) can be covered beyond the end of the calendar year of the Dependent child's nineteenth (19th) birthday, up to the end of the calendar year of their twenty-fifth (25th) birthday, provided **all** of the following conditions are met:

(i) they are unmarried;
(ii) they are financially dependent upon the Member;
(iii) they are a member of the Member's household;
(iv) they are related to Member by blood, marriage or legal adoption.

Note that Dependency for tax purposes as defined by the IRS is not required.

(c) Your unmarried dependent children can be covered beyond the end of the calendar year of their 25th birthday (if covered under this program at the end of the calendar year of their 25th birthday and continuously thereafter) if they are full time students and dependent on you for a majority of their support, provided **all** of the following conditions are met:

(i) they are unmarried;
(ii) they are dependent upon the Member for more than one/half of their financial support;
(iii) they are a member of the Member's household;
(iv) they are related to Member by blood, marriage or legal adoption;
(v) Dependency for tax purposes as defined by the IRS is not required.

(d) Dependents, who are the employee Member's child(ren), who are totally and permanently disabled, either physically or mentally, may be eligible for coverage as a member if they meet the following requirements.

(i) They are currently covered under the Plan and are totally and permanently disabled at the end of the calendar year of their 25 birthday and continuously thereafter.
(ii) they are incapable of self-sustaining employment.
(iii) BPA is notified of the conditions before the end of the year in which the dependent turns 25
(v) the dependent is unmarried and dependent on the subscriber for primary support and care.

Contact BPA, the Plan Administrator, if you have questions about coverage of disabled dependents under this section.

(e) Principally Supported Children are children who are not the offspring of the employee or spouse, but are related by blood or marriage. They may be eligible for coverage if they meet the following requirements.

(i) The child is under 19 and unmarried.
(ii) The child is a member of the employee's household.
(iii) The child was claimed as a dependent on the employee's most recent federal income tax return.
(iv) Prior to requesting the addition of the child, the employee has provided support for at least six consecutive months. (Following this period, there is a 90-day waiting period for

coverage to begin.)

(v) Must have legal guardianship of principally supported child(ren).

The employee will need to fill out a BPA Enrollment and Change Form and submit a sworn affidavit stating the date principal support began and a copy of their most recent federal income tax return listing the child as a dependent.

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

2.04 Changes(s) In Coverage/Open Enrollment

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

(a) If an employee Member declines enrollment for himself or his Dependents (including his spouse) because of other health insurance coverage, he may in the future enroll himself and/or his Dependents in this Plan, prior to the next Open Enrollment, provided that he completed a written enrollment and authorization for payroll deduction within 30 days after the other health insurance coverage ends. In addition, if an Employee member has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he may in the future enroll himself and/or his Dependents in this plan, prior to the next Open Enrollment, provided that he complete a written enrollment and authorization for payroll deduction within 30 days after the marriage, birth, adoption, or placement for adoption. However, the 30 day period for enrollment prior to the next Open Enrollment is extended to 60 days after an employee and/or his Dependents lose coverage under Medicaid or a children's health insurance program (CHIP) due to loss of eligibility (rather than non-payment), or after an employee and/or his Dependents become eligible for government premium assistance under Medicaid or CHIP.

(b) Employees who are required to contribute toward the cost of their coverage, and who have not completed enrollment and written authorization for payroll deduction within thirty-one (31) days after they initially become eligible for coverage, may enroll as Members in the next following Open Enrollment or succeeding Open Enrollments thereafter, with coverage to begin effective on the first day of the month of next Open Enrollment unless they are entitled to enroll earlier due to family status changes as described in paragraph (a) above.

2.05 Termination of Membership

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

(a) On the first day of the month for which the Employer's contributions are no longer current; provided that coverage shall be reinstated effective the first of the month for which contributions on the Member's behalf resume provided all other eligibility requirements are met; or,

(b) On the first day which the Member's contributions (if required) are not current (over 30 days past due), provided that coverage may be reinstated at the next following Open Enrollment on payment of required contributions thirty (30) days in advance (and provided all other eligibility requirements are met), a Member on approved FMLA may be reinstated when the Member returns to work; or,

(c) The day the employee Member ceases to be a member of a class of employees eligible for coverage; or,

(d) The date which the class of employees to which the employee Member belongs is no longer eligible for coverage; or,

(e) The date on which the Plan terminates.

(f) For Dependents, the date the employee Member's coverage terminates. Dependent coverage will never extend beyond the termination date of the employee Member's coverage termination date.

(g) You may terminate your coverage when there is a qualifying event (family status change) or during open enrollment. The written request must indicate the event.

2.06 Military Service

If your coverage terminates because you enter or are drafted into active military service, your eligibility for coverage under the Plan will be reinstated if you make application for reemployment with your Employer in an eligible classification within the time required by the Uniformed Services Employment Act of 1994 (USERRA). If you meet the requirements of the USERRA eligibility for the employee Member and eligible Dependents will be reinstated on the day the employee Member returns to work, regardless of whether self payments to continue coverage are made while you are in the military as permitted under COBRA (see Section III below) and USERRA. It is important for you to notify the Plan Administrator, BPA, as soon as possible after you enter active military service, and as soon as possible after your discharge from active service.

2.07 Notice of Creditable Coverage for Pre-existing Conditions

The Health Insurance Portability and Accountability Act (HIPAA), a federal law, limits the amount of time that group health plans can exclude coverage for a new enrollee's pre-existing health conditions to 12 months (or 18 months for late enrollees). But that waiting period (exclusion period) can be reduced by the number of months the individual was covered previously under another health plan, including COBRA continuation coverage (see Section III), so long as there has not been a gap of more than 63 days in the individual's coverage. If your coverage under this Plan ends for any reason, you will receive from the Fund a "Certificate of Group Health Plan Coverage" which you should present to your new group health plan. That new group health plan will then "credit" your months of coverage under this Plan against any exclusion period for pre-existing conditions imposed by the new plan, provided you did not have a gap of more than 63 days in your coverage.

SECTION III

PPO PROVISIONS & PRECERTIFICATION OF BENEFITS

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

3.01 Preferred Provider Organization - This Plan is a Preferred Provider Organization PPO medical plan that provides coverage for a wide range of medical expenses for the treatment of illness or injury. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your PPO plan, you can directly access any physician, hospital or other health

care provider (network or out-of-network) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through network providers or out-of-network providers. The plan will pay for covered expenses up to the maximum benefits shown in this Booklet. Coverage is subject to all the terms, policies and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers, Exclusions, Limitations* and *Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

This PPO plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to plan members at a reduced fee called the negotiated charge. This PPO plan is designed to lower your out-of-pocket costs when you use network providers for covered expenses. Your deductibles, copayments, and coinsurance will generally be lower when you use participating network providers and facilities.

You also have the choice to access licensed providers, hospitals and facilities outside the network for covered benefits. Your out-of-pocket costs will generally be higher. Deductibles, copayments, and coinsurance are usually higher when you utilize out-of-network providers. Out-of-network providers have not agreed to accept the negotiated charge and may balance bill you for charges over the amount Aetna/CBT pays under the plan. Your out-of-pocket costs may vary between network and out-of-network benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

3.02 Availability of Providers - Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice. If the physician initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

3.03 Ongoing Reviews - Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Booklet. If Aetna determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting BPA to seek a review of the determination. Please refer to the Appeal of Denied Claim or Adverse Benefit Determination *within* this Booklet.

To better understand the choices that you have with your PPO plan, please carefully review the following information.

3.04 Accessing Network Providers and Benefits

- You may select any network provider from the Aetna network provider directory or by logging on to Aetna's website at www.aetna.com. You can search Aetna's online directory, DocFind®, for names and locations of physicians and other health care providers and facilities. You can change your health care provider at any time.
  - If a service you need is covered under the plan but not available from a network provider, please contact Member Services at the toll-free number on your ID card for assistance.
- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require precertification with Aetna to verify coverage for these services. You do not need to Precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of pocket cost to you as a result of a network provider's failure to Precertify services. Refer to the *Understanding Precertification* section for more information.

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- You will not have to submit medical claims for treatment received from network providers. Your network provider will take care of claim submission. Aetna will directly pay the network provider less any cost sharing required by you. You will be responsible for deductibles, payment percentage, and copayment, if any.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe toward your deductible, copayment, payment percentage, or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits Important Note: You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will need to satisfy any applicable deductibles before the plan will begin to pay benefits.
- The plan contains a deductible carryover feature, which means that any portion of the deductible met in the fourth quarter (October through December) carries over to the deductibles required for the next year.
- For certain types of services and supplies, you will be responsible for any copayment shown in the *Schedule of Benefits.*
- After you satisfy any applicable deductible, you will be responsible for your payment percentage or covered expenses that you incur. Your payment percentage is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply. You will be responsible for your payment percentage up to the maximum out-of-pocket limit applicable to your plan.
- Once you satisfy the maximum out-of-pocket limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limit. Refer to your *Schedule of Benefits* section for information on what specific limits, apply to your plan.
- The plan will pay for covered expenses, up to the maximums shown in the *Plan Benefits* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *Plan Benefits* or *Schedule of Benefits* sections.
- You may be billed for any deductible, copayments, or payment percentage amounts, or any non-covered expenses that you incur.

3.05 Accessing Out-of-Network Providers and Benefits -

- You have the choice to directly access physicians, hospitals or other health care providers that do not participate with the Aetna provider network. You will still be covered when you access out-of-network providers for covered benefits. Your out-of-pocket costs will generally be higher.
- Out-of-network providers have not agreed to accept the negotiated charge and may balance bill you for charges over the amount Aetna pays under the plan. Deductibles and payment percentage are usually higher when you utilize out-of-network providers. Except for emergency services, Aetna will only pay up to the recognized charge.
- You select an out-of-network health care provider or facility for covered benefits. Should you receive covered services from an out-of-network provider, you will be required to pay a deductible for most covered services. However, you will not be required to pay an out-of-network deductible if an in-network provider refers to you to an out-of-network provider.
- Precertification is necessary for certain services. When you receive services from an out-of-network provider, you are responsible for obtaining the necessary precertification from Aetna. Your provider may Precertify your treatment for you; however you should verify with Aetna prior to the procedure, that the provider has obtained precertification from Aetna. If your treatment is not precertified, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the precertification toll-free number on your ID card to Precertify services. Refer to the *Understanding Precertification* section for more

information on the precertification process and what to do if your request for precertification is denied.

- When you use physicians and hospitals that are not in the network you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to an out-of-network provider. Aetna will reimburse you for a covered expense up to the recognized charge, less any cost sharing required by you.

- If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider.
- You will receive notification of what the plan has paid toward your medical expenses. It will indicate any amounts you owe towards your deductible, payment percentage, or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note - Failure to Precertify will result in a reduction of benefits under the plan. Please refer to the *Understanding Precertification* section for information on how to Precertify and the precertification benefit reduction.

3.06 Cost Sharing for Out-of-Network Benefits - You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- You must satisfy any deductibles before the plan begins to pay benefits.
- After you satisfy any applicable deductible, you will be responsible for any applicable payment percentage for covered expenses that you incur. You will be responsible for your payment percentage up to the maximum out-of-pocket limit applicable to your plan.
- Your payment percentage will be based on the recognized charge. If the health care provider you select charges more than the recognized charge, you will be responsible for any expenses above the recognized charge.
- Once you satisfy any applicable maximum out-of-pocket limit, the plan will pay up to 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limit. Refer to the *Schedule of Benefits* section for information on what expenses do not apply and for the specific dollar limits that apply to your plan.
- The plan will pay for covered expenses, up to the maximums shown in the *Plan Benefits* or *Schedule of Benefits* section. You are responsible for any expenses incurred over the maximum limits outlined in the *Plan Benefits* or the *Schedule of Benefits* sections.

3.07 Understanding Precertification - Certain services, such as inpatient stays, certain tests, procedures and outpatient surgery require precertification by Aetna. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate. You do not need to Precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to Precertify services.

When you go to an out-of-network provider, it is your responsibility to obtain precertification from Aetna for any services or supplies on the precertification list below. If you do not Precertify, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring precertification follows on the next page.

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Important Note - Please read the following sections in their entirety for important information on the precertification process, and any impact it may have on your coverage

3.08 The Precertification Process - Prior to being hospitalized or receiving certain other medical services or supplies there are certain precertification procedures that must be followed. You are responsible for obtaining precertification when receiving services from a non-network provider. You or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to Precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification pursuant to this Booklet in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made:

- For non-emergency admissions: You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
- For an emergency outpatient medical condition: You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
- For an emergency admission: You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
- For an urgent admission: You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
- For outpatient non-emergency medical services requiring precertification: You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your physician of the precertification decision. If your precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan. When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the *Appeal of Denied Claim or Adverse Benefit Determination s*ection of this Booklet.

3.09 How Failure to Precertify Affects Your Benefits - A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means Aetna will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary precertification from Aetna prior to receiving services from an out of-network provider. Your provider may Precertify your treatment for you; however you should verify with Aetna prior to the procedure, that the provider has obtained precertification from Aetna.

If your treatment is not precertified by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered (See Section 3.10).

3.10 How Your Benefits for Inpatient and Outpatient Care, Procedures and Treatment are Affected - The chart below illustrates the effect on your benefits if necessary precertification for outpatient or inpatient services, procedures and treatments is not obtained.

If precertification is:	Then the expenses are:
Requested and approved by Aetna	Covered.
Requested and denied	Not covered, may be appealed.
Not requested, but would have been covered if requested	Covered after a precertification benefit reduction is applied.*
Not requested, would not have been covered if requested.	Not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your precertification requirement was not met will not count toward your deductible or payment percentage or maximum out-of pocket limit.

If the required Pre- Certification is not obtained, those covered charges stated above which are determined to be medically necessary for inpatient hospital confinement and physician in-hospital visits will be reimbursed at 80 percent (80%) of the amount after deductible that would have otherwise have been paid in accordance with your Plan Summary of Benefits and Pre-Certification. You will be responsible for the remaining 20 percent (20%). The disadvantage to receiving services without prior approval is you will not know before admission whether the care is a covered expense.

If you were given prior notice of Aetna's (or the plan's) denial of benefits before admission began, or if you accepted such liability by entering into a prior agreement with your doctor, you will be responsible for all charges (both hospital and doctor) resulting from the admission.

SECTION IV

PLAN BENEFITS

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

4.01 General Information: The Plan is provided by your employer, through Consolidated Benefit Trust (CBT). CBT has retained Benefit Plan Administrators, Inc., (the "Plan Administrator") to provide plan and benefit administrative services for this Plan. You will receive most of your information about your claims and benefits under the Plan from BPA. You should keep BPA informed of any important family changes.

Aetna's participating arrangements with health care facilities, doctors, and other professionals limit your out-of-pocket expenses. Aetna is the "Claims Administrator" for the Plan and will process claims for Benefits in accordance with its arrangements with participating providers.

Benefits are paid subject to the allowable percentage and the annual deductible, if applicable. Specific information relating to copays and deductibles that apply to you can be found in Appendix A, the Schedule of Benefits at the back of this booklet.

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Some of the specific benefits described in this part of the Plan Description may not be provided under the specific Plan that covers you. Please refer to the Schedule of Benefits for your specific coverage.

4.02 **Preventive Services-Based on In-Network Services Only**

Health Maintenance Exam	Covered once per calendar year. Benefits include comprehensive history and physical examination.
Annual Gynecological Exam	Covered once per calendar year. Benefits include history and examination.
Pap Smear Screening	Covered once per calendar year. Benefits include laboratory services only. More frequent pap smears are covered for the following conditions: • Previous surgery for vaginal, cervical or uterine or malignancy • Presence of a suspected lesion in the vaginal, cervical or uterine areas • Post-surgery
Well-Baby and Child Care	Covered to monitor the development and well being of children. These visits are covered through age 15 as indicated on the Schedule of Benefits.
Immunizations	Covered through age 16 and include the following: • Diphtheria, tetanus, and pertussis (DTP) vaccines (up to five doses) • Measles, mumps, and rubella vaccines (up to two doses of each) • Tetanus Immune Globulin (human) and Antitoxin (horse serum) • Polio vaccine (up to six doses) • Diphtheria toxoid • Hepatitis B vaccine (up to three doses) • Chicken pox vaccine • Influenza type B – HIB (up to four doses) The Plan periodically updates the list of eligible immunizations. Please contact BPA to inquire about immunizations not listed above.
Fecal Occult Blood Screening	Covered once per calendar year per member
Flexible Sigmoidoscopy Exam	Covered once per calendar year per member
Prostate Specific Antigen (PSA) Screening	Covered once per calendar year per member
Chemical Profile	Covered once per calendar year per member
Complete Blood Count	Covered once per calendar year per member
Urinalysis	Covered once per calendar year per member

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	Chest X-ray	Covered once per calendar year per member
	EKG	Covered once per calendar year per member
4.03	**Mammography - One per calendar, no age restrictions.**	
	Mammography Screening	Up to the allowed UC&R as indicated on the Schedule of Benefits
4.04	**Physician Office Services**	
	Office Visits	Covers medical care visits and therapeutic injections in a physician's office for a diagnosis and treatment of any disease or illness (except mental).
	Outpatient and Home Visits	Covers medical care visits and therapeutic injections in a patient's home or hospital outpatient department for an examination, diagnosis and treatment of any disease or illness (except mental).
	Office Consultations	Covers medical care visits and therapeutic injections in a physician's office for diagnosis and treatment of any disease or illness (except mental).
4.05	**Emergency Medical Care**	
	Hospital Emergency Room	Approved diagnosis – Hospital and physician charges for the initial examination and treatment of accidental injuries and life threatening medical emergencies
	Urgent Care Center	Visits for the examination, diagnosis and treatment of illness or injury.
	Ambulance Services	Professional ambulance services to the nearest hospital qualified to treat the patient's condition. Ambulance services must be medically necessary and prescribed by a physician. Benefits are provided for both ground and air transport. Services provided by a fire department, rescue squad or other carriers whose fee is a voluntary donation are not covered.
4.06	**Diagnostic Services**	
	Laboratory and Pathology	For the examination of blood, tissue, urine and other body fluids
	Radiology	Diagnostic and therapeutic x-rays, radioactive isotopes, cobalt, ultrasound and CAT scans of the head and body.
4.07	**Maternity Services Provided By A Physician**	
	Pre- and Post-Natal Care	Delivery including pre and post natal care of the mother and routine newborn nursery care during the mother's stay.
4.08	**Hospital Care**	
	Inpatient Care	Unlimited days in a semi-private room. This includes meals, special diets, and general nursing care for general

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general medical conditions as well as hospital services and supplies.

Inpatient Consultations	Inpatient services of a consulting physician in the diagnosis and treatment of a condition.
Chemotherapy	Payable if administered in a hospital, in the outpatient department of a hospital or in a physician's office. Benefits include the administration and cost of FDA-approved drugs if the treatment is not considered Experimental or Investigatory. Coverage includes three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

4.09 **Alternatives to Hospital Care**

Skilled Nursing Care

You are covered for up to 120 days per member per calendar year when the patient is suffering from or gradually recovering from an illness or injury. The patient's physician must prescribe skilled nursing care. Skilled nursing care is not payable for custodial care, care for senility or mental retardation or care for substance abuse or for long-term mental illness.

Home Health Care

Home Health Care is an alternative to long-term hospital care by offering coverage for care and services at the patient's home. Services must be prescribed by the patient's attending physician, be medically necessary and be provided by a licensed home health care agency.

A covered person must have physician certification warranting the need for home health care as a medically necessary alternative to hospital confinement. Other services are available on a 30 day benefit period. The benefit period may be renewed with proper certification from the covered person's physician. Covered services include:

- Part time skilled nursing care rendered by a registered nurse or licensed practical nurse.
- Medical care rendered by a home health aide or nurses assistant under the direct supervision of a registered nurse.
- Medical supplies other than prescribed medications and medicines requiring a written prescription.
- Rental of medical equipment (not to exceed purchase price)
- Physical therapy, occupational therapy, speech therapy, social guidance, and nutritional guidance provided by a home health care agency.
- Hospital services and supplies related to the injury or illness which required or would have required hospital confinement and would normally be

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provided by the hospital.

Hospice Care

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

Occasional Respite Care of up to 5 day's duration within a 30 calendar day period to relieve family members or other persons caring for the member at home.

When a covered member is accepted into an approved hospice program, they are covered up to allowable dollar maximum of two 90-day periods and one 30-day period of care. Coverage includes:

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

Check with BPA Customer Service about the current dollar amount allowed for hospice care.

4.10 **Surgical Services**

Surgery

Including all related surgical services, anesthesia, and surgical assistance – Covered for the diagnosis and treatment of diseases and injuries. Surgical benefits include all related pre-and post-operative medical care by the surgeon. NOTE: Multiple surgeries (two or more surgical procedures during one operation) are subject to payment limitations:

- When surgeries are through different incisions, the Plan pays the approved amount for the primary surgery (the procedure with the higher benefit payment), plus one half of the approved amount for any additional procedures
- When surgeries are through the same incision, the Plan pays the approved amount for the primary surgery only.

Voluntary Sterilization

Covered for both male and female patients regardless of medical necessity.

Cosmetic or Reconstructive

Payable only for the correction of birth defects, functional abnormalities resulting from accidental injuries, the

injuries, the correction of deformities resulting from severe trauma, or cancer surgeries, such as breast reconstruction following mastectomies.

4.11 **Human Organ Transplant**

Liver, Heart, Lung, Pancreas, Heart-Lung

- Procurement , surgical storage and transportation costs of donated organs (subject to the lifetime maximum)
- Anti-rejection drugs (subject to the lifetime maximum)

- Transportation to and from the transplant facility, meals and lodging up to $10,000 for the patient and one companion (two if the patient is a minor). Subject to the lifetime maximum.

- Travel expenses for an additional person when a living organ donor is involved (subject to the lifetime maximum).

Kidney, Cornea, Skin and Bone Marrow

Benefits are payable for services and expenses for transplantation of organs and tissues when performed in a participating facility. Benefits include evaluation and surgical removal of the donated part from a living or non-living donor. These transplants are subject to basic coverage limitations and exclusions.

Bone Marrow Transplants

Covered: Autologous bone marrow and peripheral blood stem cell transplants (including harvesting and storing the marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year)

Allogeneic bone marrow and peripheral blood stem cell transplants (including harvesting the marrow and/or peripheral blood stem cells if the donor is:

- ✓ A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
- ✓ Not a first degree relative and matches five of the six important HLA genetic markers with the patient
- ✓ High-dose chemotherapy
- ✓ Total body radiation
- ✓ Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
- ✓ A search of the National Bone Marrow Donor Program Registry for a donor.

Note: A search will begin only when the need for a

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donor is established.

Infusion of colony stimulating growth factors

Hospitalization in an intensive care unit, special care unit or private room

Services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting as detailed above).

Allogenic bone marrow and peripheral blood stem cell transplants are covered to treat:

- ✓ Acute lymphocytic leukemia
- ✓ Acute non-lymphocytic leukemia
- ✓ Aplastic anemia
- ✓ Beta thalassemia, major
- ✓ Chronic myeloid leukemia
- ✓ Hodgkin's disease (relapsed and stage III or IV)
- ✓ Huler's syndrome
- ✓ Myelodysplastic syndromes
- ✓ Neuoblastoma (stage III or IV)
- ✓ Non-Hodgkin's lymphoma (intermediate or high grade)
- ✓ Osteopetrosis
- ✓ Severe combined immune deficiency disease
- ✓ Wiskott-Aldrich syndrome
- ✓ Sickle cell disease (when complicated by stroke)
- ✓ Myelofibrosis

Autologous bone marrow and peripheral blood stem cell transplants are covered to treat:

- ✓ Acute lymphocytic leukemia
- ✓ Acute non-lymphocytic leukemia
- ✓ Germ cell tumors of the ovary, testis, mediastinum, retroeritoneum
- ✓ Hodgkin's disease (stage III or IV)
- ✓ Neuroblastoma (stage III or IV)
- ✓ Non-Hodgkin's lymphoma (intermediate or high grade)
- ✓ Metastatic breast cancer (stage IV)
- ✓ Multiple myeloma
- ✓ Primitive neuoectodermal tumors
- ✓ Ewing's sarcoma
- ✓ Medulloblastoma
- ✓ Wilms' Tumor

Also covered:

- ✓ Any services related to or for high-dose chemotherapy, total body radiation, allogeneic or

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autologous bone marrow and/or peripheral blood stem cell transplants to treat conditions other than those listed above if the services are not otherwise excluded from coverage as experimental or investigational. We also cover antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

- ✓ Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted, standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care and be medically necessary for the illness or injury being treated.

We do not cover:

- ✓ Any services related to or for allogeneic bone marrow transplants and/or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements.
- ✓ Purging of and/or positive stem cell selection of:
  - ✓ Bone marrow stem cells or
  - ✓ Peripheral blood stem cells
  - ✓ Harvesting and storage cost of bone marrow and/or peripheral blood stem cells if not intended for transplant within one year.
  - ✓ Health care services provided by persons who are not legally qualified or licensed to provide such services

Services which are not medically necessary;

- ✓ Any facility, physical or associated services related to any of the above named exclusions.
- ✓ Experimental or Investigational Services

4.12 **Mental Health Care and Substance Abuse Treatment**

Inpatient Mental Health Care And Substance Abuse Care

Covered up to the mental health care dollar maximum. The following benefits are payable when provided in approved day or night care centers:

- Services provided by facility staff
- Prescribed drugs
- Electroshock therapy administered by or under the supervision of a physician
- Psychological testing
- Individual and family counseling

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Outpatient Mental Health Care	Payable when provided in an approved facility or physician's office and provided by a physician or fully licensed psychologist. Services are covered up to the annual and lifetime dollar maximums and include benefits for individual and group therapy, psychological testing, convulsive therapy treatment and family counseling.
Outpatient Substance Abuse	Payable when provided in an approved facility or a physician's office and provided by a physician or fully licensed psychologist. Services are covered up to the stated dollar amount.

IMPORTANT: Inpatient mental health care and substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. Your physician must call Aetna to pre-certify

all hospital admissions for mental health and substance abuse for both in Michigan and outside of Michigan.

4.13 **Other Services**

Allergy Testing and Therapy	Includes scratch and puncture tests, ultrasound and radio therapy treatment and injections.
Chiropractic Spinal Manipulation	Limited to manipulation of the spine and services are covered up to a maximum number of visits (as indicated the Schedule of Benefits) per calendar year per member.
Outpatient Physical, Speech, and Occupational Therapy	Provided for rehabilitation and is payable for up to a combined 60 visits per calendar year. Physical, occupational and speech therapy must be: • Prescribed by a physician. • Given under the supervision of a physician or by an appropriate licensed therapist. • Given for a condition expected to improve within a reasonable and generally predictable period of time. Examples of covered therapy are: • Physical therapy prescribed to restore the use of legs. • Physical therapy used to accelerate the healing of an acute injury or illness involving muscles or joints. • Speech therapy to restore speech following a stroke. Therapy benefits are not payable for: • Long-standing, chronic conditions such as arthritis. • Health club or spa memberships. • Developmental conditions or learning disabilities. • Congenital or inherited speech abnormalities except for dependent children. • Inpatient hospital admissions principally for speech

or language therapy.
- Inhalation therapy and hyperbaric oxygenation therapy.

Hearing Care

These services require authorization from a physician as services are not covered without physician authorization.

Your physician must refer you to a physician-specialist who is board certified as an otologist, otolaryngologist, or otorhinolaryngologist. This physician-specialist determines whether the hearing loss can be offset by a hearing aid. The medical hearing loss examination is covered under the standard medical care benefits of this program and is not included in the maximum benefit limitation.

Covered expenses are:

- An audiometric examination for either ear, or both ears, that:
  - is prescribed by a physician-specialist;
  - is performed by a physician-specialist or audiologist or hearing aid specialist/dealer;
  - is performed within six months of a medical hearing loss examination by a physician-specialist;
  - includes tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination; and
  - includes a summary of findings.

- A hearing aid evaluation test and a conformity test for either ear, or both ears, that:
  - is prescribed by a physician-specialist;
  - is performed following a medical hearing loss examination and an audiometric examination; and
  - is performed by a physician-specialist or audiologist or hearing aid specialist/dealer.

- The actual cost and dispensing fee for a hearing aid for either ear, or both years. The hearing aid must be:
  - designed to be worn in the ear, behind the ear, or on the body;
  - prescribed by a physician-specialist, audiologist or hearing aid specialist/dealer based on the most recent audiometric examination and hearing aid evaluation test;

  - the make and model prescribed by the

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	physician-specialist, audiologist, or hearing aid specialist/dealer; and • provided by a hearing aid specialist or dealer. There is a plan maximum benefit adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a thirty-six (36) month period. Contact BPA Customer Service about the current dollar amount. In addition, an audiometric examination, a hearing aid evaluation, and a conformity test for each ear will be paid during a thirty-six (36) month period. Expenses not covered for hearing care include: • an audiometric examination by an audiologist or hearing aid specialist/dealer that is not prescribed by a physician-specialist; • hearing aids delivered more than sixty (60) days after coverage ended; • the trial and testing of different makes and models of hearing aids when such testing is not supported by the results of the most recent audiometric examination; • charges for "spare" hearing aids; • replacement of hearing aids that are lost or broken, unless this benefit was not used for at least thirty-six (36) months; • hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements.
Durable Medical Equipment	Rental or purchase of physician prescribed equipment that is reusable and appropriate.
Prosthetic and Orthotic Appliances	Covered when prescribed by your physician to replace or correct a missing part of the body. Appliances or devices must be approved by BPA.
Private Duty Nursing	Covered when the patient's condition requires 24-hour continuous skilled care by a professional nurse on a one-to-one basis. Services must be prescribed by your personal care physician and provided by a registered or licensed practical nurse. Your physician must complete a Certification Statement each month the patient is required to have private duty nursing care. Non-skilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not a benefit. Although a physician must prescribe private duty nursing, it does not guarantee payment.
Diabetes Coverage	Coverage for certain diabetic prescription drugs,

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supplies, equipment and self-management training. These benefits are subject to co-payments and deductibles. Services must be medically necessary and prescribed by an M.D. or D.O. Benefits are as follows:

- Syringes and needles for Insulin purposes only
- Test strips for glucose monitors
- Visual reading and urine testing strips
- Lancets
- Spring-powered lancet devices
- Insulin pumps and medical supplies required for the use of the pump
- Blood glucose monitors and blood glucose monitors for the legally blind

Outpatient Diabetes Management Program	Diabetic self-management program training is an interactive, collaborative process involving patients with diabetes, their physicians and certified diabetes instructors. Appropriate training should provide members with the knowledge and skills needed to care for themselves on a day-to-day basis, manage diabetic crises and make any lifestyle changes needed to manage the disease successfully. Outpatient self-management and training services may be covered only if the physician who is managing the member's diabetic condition certifies that such services are needed.

4.14 Breast Cancer Benefits

Under the Women's Health and Cancer Rights Act of 1998 you may be entitled to certain benefits if you receive medical treatment in connection with a mastectomy that elects breast reconstruction, which include:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of medical complications for all stages of mastectomy, including lymph edemas (swelling associated with the removal of lymph nodes).

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

4.15 Childbirth Benefits - Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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, the Federal law generally does not prohibit the mother's or 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).

4.16 Prescription Drugs: The Prescription Drug Program Manager is indicated in the Schedule of Benefits, if applicable. This Prescription Program protects against unpredictable costs of health sustaining drugs and at the same time is designed to save money through the use of generic equivalent drugs. Generic

equivalents are simply drugs that can be produced by more than one manufacturer and distributed under more than one name. However, it is important to understand that the Food and Drug Administration requires these Grade AB drugs must meet the same standards as brand name drugs. Your pharmacist has a complete listing of the generic equivalent drugs covered under this program.

Brand name drugs will be dispensed only if the doctor has indicated "Dispense as Written" on the prescription or if a member asks for the brand name drug. Otherwise, with the exception of insulin, if there is a generic equivalent to a brand name drug, the pharmacist will automatically dispense the generic equivalent. Brand name drugs are subject to a higher copay unless the doctor has indicated "Dispense As Written" or a generic is not available. If you ask for the brand name drug, you will have to pay a higher copay amount unless a generic is not available. (See Appendix "B")

Prescription drugs which are billed by Participating Pharmacists:

TYPE OF SERVICE	DESCRIPTION OF BENEFIT
Prescription Drugs	Injectable insulin and federal legend drugs dispensed up to a 34-day supply or, for certain maintenance drugs, 100 unit doses, whichever is greater.
Brand Drugs	Those medications that are under patent with the Food and Drug Administration and are only manufactured by one pharmaceutical company.
Formulary Drugs	A variety of brand name drugs that the Prescription Drug Manager has negotiated with the manufacturer(s) to provide a discounted rate for. These drugs are subject to change as the negotiated contract with each manufacturer ends or when the drug has been released from patent.
Generic Drugs	A drug that is produced by more than one pharmaceutical company.
Genetically Engineered	Also known as "biologicals". These drugs involve the use of human DNA properties – cells, tissue and genes – and manipulation of them with bacteria or yeast to create a therapeutic drug. There are no chemical compounds found in these drugs.
Lifestyle Drugs	These drugs may be considered differently, depending on the Prescription Drug Manager. The most common ones are those that assist with obesity, impotency, and hair loss.
Multi-source Drugs	Classification of drugs which are available in both Brand and Generic.
Maintenance Drugs	Prescribed medication(s) that are prescribed for longer than 90 days at a time. Typically are used for treating lifelong & chronic conditions.
"COB"	Coordination of Benefits – When a patient has dual prescription coverage, the pharmacy will provide the patient with the lower of the two co-payment amounts.
"DAW"	Dispense As Written - This is applicable when a patient receives a multi-source brand medication where a FDA approved generic form is available. Should the prescribing physician not indicate Dispensed As Written, the patient will be responsible for the higher copay unless a

	generic is not available. Should the physician indicate Dispense as Written, the patient will be required to pay the same copay as for generics. (see Rx Appendix "B").
Mail Order	(If provided as a benefit as indicated on the Schedule of Benefits) Should a member desire to receive prescribed maintenance medications through the mail order pharmacy, the member must submit the prescription to the Prescription Drug Manager on the form which was included in the informational packet provided the member at enrollment. Mail order pharmacy services are available to the member for the second and subsequent prescriptions. Details of the mail order prescription service is as follows: (i) Covered Prescribed Medications: Covered prescribed medications include Multi-source, Generics (Minimum AB Grade), and Brand Name Drugs (Federal Legend). (ii) Co-payment Amount: The member co-payment can be found in the Schedule of Benefits located at the in appendix "A" in the back of this booklet.
Dispensed Quantities:	The dispensed quantities are for maintenance drugs limited to a 90 day quantitative supply.
Co-payment	As indicated in the Schedule of Benefits.

Benefits at Participating Retail Pharmacies: For a member to receive benefits through a participating pharmacy, the member must present the pharmacist with the member's ID card. A list of Participating Pharmacies can be obtained from the Plan Administrator, BPA and/or online at Caremark.com . Other important information regarding prescribed medications is as follows:

(i) Covered Prescribed Medications: Covered prescribed medications include Multi Source, Generics (Minimum AB Grade), and Brand Name Drugs (Federal Legend).
(ii) Co-payment Amount: The member co-payment can be found in the Schedule of Benefits located in Appendix B.
(iii) Dispensed Quantities: The dispensed quantities are 34-day supply, or 100 capsule limit per prescription.

Benefits at Non-Participating Pharmacies: When a member goes to a non-participating pharmacy, they must pay the full charge for each prescription or refill. The member will be reimbursed 75% of the approved amount minus the copay per prescription. If the member requests a brand name drug instead of the generic equivalent, they will be reimbursed 75% of the approved amount for the generic equivalent drug minus your co-payment.

Prescription Drugs Covered:

(i) Drugs which, under Federal Law, are required to bear the legend: "CAUTION: Federal Law prohibits dispensing without prescription."
(ii) A compound medication of which at least one ingredient is a Federal Legend Drug.
(iii) Other drugs which, under the applicable State Law, may only be dispensed upon prescription by a physician.
(iv) Other drugs may be covered. Please see the Schedule of Benefits for a complete list of covered drugs.

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EXCLUSIONS AND LIMITATIONS

5.01 **Exclusions:** In addition to applicable limitations appearing elsewhere in this Plan Description, the following services are excluded under this Plan:

- Services paid by Medicare as the primary benefit plan (see Section 6.05);
- Services covered in full by other group insurance contracts, or any other service plan;
- Services provided before the effective date of this Plan;
- Services provided after termination of this Plan;
- Services which are not Medically Necessary;
- Treatment of mental disorders extending beyond period necessary for diagnostic evaluation of mental retardation or beyond period where favorable modification cannot result;
- Health tests unrelated to previously diagnosed conditions except as specifically provided;
- Charges determined to be unreasonable;
- Research or Experimental services and treatment;
- Weight reduction by diet control;
- Services that are not health care services (personal and convenience items, completion of forms, cost of transportation except ambulance service);
- Services and supplies not prescribed by a physician;
- Services by persons not qualified or licensed;
- Services provided by employer facilities;
- Services for occupational injuries or disease;
- Services available without cost, through the government or under a government health plan;
- Services resulting from military action or war, declared or undeclared;
- Custodial care, rest therapy, care in nursing or rest home facilities;
- Hospitalization principally for observation or diagnostic evaluation, physical therapy, x-ray or laboratory tests;
- Pre-marital, sports, or pre-employment examinations, and other related services;
- A service rendered by a doctor who ordinarily resides in the same household with the employed member or who is a member of the employed member's immediate family (i.e. children or spouse) where charges are not normally made;
- Artificial insemination, in-vitro fertilization, or any other fertilization procedure to ensure pregnancy.
- Acupuncture
- No hearing aids or routine testing unless otherwise specified in the Schedule of Benefits.

In addition, the prescription drug program does not cover:

- Drugs costing less than the co-payment requirement;
- Drugs requiring a prescription by state law, but not federal;
- Drugs that are experimental or research in nature or are not FDA approved for the condition that are being prescribed;
- Any covered drug, which is consumed at the time or place of the prescription order;
- Administration of drugs;
- More than a 34-day supply, except for specified maintenance drugs, which are covered in 100-unit doses;
- Refills not authorized by a physician;
- Refills dispensed after one year from the date of the original order;
- Medications covered by any Workers' Compensation Law or available without charge from any government program;
- Medications provided to you as a hospital inpatient or outpatient and covered under the basic contract.
- Toenail fungus medications

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- Vitamins (except prenatal)
- The following are also excluded unless otherwise indicated in the Schedule of Benefits
  - ✓ Fertility Agents.
  - ✓ Erectile Dysfunction Medications.
  - ✓ All cosmetic Drugs.
  - ✓ Physician prescribed smoking cessation products.
  - ✓ Diet Medications.
  - ✓ Genetically engineered medications.
  - ✓ Injectable insulin, including needles and syringes.
  - ✓ Federal Legend Oral Contraceptives and Devices.
  - ✓ Lifestyle Medications.
  - ✓ Injectables (excluding insulin or others).
  - ✓ AIDS medications.

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

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

SECTION VI

COORDINATION OF BENEFITS

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

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

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

(a) Benefits of any Other Plan which does not contain a provision for coordination with other plans are determined prior to determination of any benefits of this Plan.

(b) Primary liability rests with the plan under which the covered Member is eligible as a covered

employee. Secondary liability rests with the plan under which the covered Member is eligible as a dependent. In situations where the covered Member is the employee and also is covered as an employee by an Other Plan (as defined in Section 1.22), the Order of Benefit Determination will be those rules as outlined in subsections 6.03(d) and 6.03(e).

(b) When neither (a), nor (b) is determinative, primary coverage for a dependent child is with the plan covering the parent whose birthday occurs earlier in the calendar year. If both parents have the same birthday, the benefits of the plan which has the covered Member claiming benefits longer are determined before those of the plan which covered the covered Member for a shorter period of time. If the Other Plan does not have this rule coordination is determined under the rules of the Other Plan.

However, when the parents of a dependent child are legally separated or divorced, the following order of benefit determination applies: the Plan covering the child as a dependent of a parent who has been given financial responsibility for medical, dental, or other health care expenses of the child under a court order of decree is primary. Otherwise, the plan covering the custodial parent will be primary; where the custodial parent has remarried, coverage of the custodial parent will be primary, followed by the plan covering the child as a dependent of the custodial parent's spouse, followed by the plan of the non-custodial parent.

(d) The Benefits of a plan which covers a Covered Member as an employee who is neither laid off nor retired (or as that employed Member's Dependent) are determined before those of a plan which covers that Covered Member as a laid off or retired employed Member (or as that Member's Dependent). If the Other Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(e) If the above rules do not establish an order of benefit determination, primary liability rests with the plan which has covered the Covered Member or Dependent continuously for the longer period of time.

(f) Where a Covered Member is subject to certain cost containment provisions under the primary plan, any cost containment sanction(s) imposed by the primary plan will not be payable as a benefit, or a secondary balance, by any of the other secondary plan(s).

(g) If a patient has dual prescription coverage the pharmacy will give the patient the lowest copay amount.

6.04 Standard Coordination of Benefits - If a dependent spouse or child is also covered as an employee, and **is** also considered a dependent under the Plan, the Coordination of Benefits provisions will apply.

6.05 Coordination with Medicare - Medicare is a federal health care program designed to provide health care benefits to persons who are age 65 and older, to persons who have End Stage Renal Disease (ESRD) and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. Medicare Part A is hospital insurance that helps pay for inpatient hospital care and certain follow-up care. Medicare Part B is medical insurance that helps pay for physician's services and other medical services and items. Medicare Part D plans help pay for prescription drug coverage. The hospital insurance (Part A) portion is provided to you at no cost. However, you must pay a monthly premium for the medical insurance (Part B) portion. If you become eligible for Medicare by reaching age 65 or because of ESRD or disability, you should enroll immediately in Medicare Parts A and B, even if you continue working. You should obtain information about Medicare enrollment from the nearest Social Security office. In those cases where the Plan cover the same items or services as Medicare, the Plan will pay first and then Medicare will supplement the Plan's coverage up to the Medicare limits. In most cases, the Plan's benefits are more generous than those provided under Medicare. Where they are not, you retain the right to file your claim with Medicare for whatever additional coverage is available. If you are eligible for Medicare, you should be receiving a special notice regarding the Plan's Prescription Drug Benefits and how those benefits relate to prescription drug benefits available under Medicare Part D. Contact the Plan Administrator if you have questions regarding retiree prescription drug coverage under this Plan and/or Medicare Part D. Generally the Plan will be the primary payer of benefits to a

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Plan will be the primary payer of benefits to a Dependent who is on Medicare because of age or disability. Also, special rules apply to a person on Medicare because of End Stage Renal Disease (ESRD), and you should check with the Plan Administrator or your local Social Security office for additional information on this.

SECTION VII

DEDUCTIBLE & COPAYMENT PROVISIONS

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

7.01 Network Calendar Year Deductible - This is an amount of network covered expenses incurred each Calendar Year for which no benefits will be paid. The network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

7.02 Out-of-Network Calendar Year Deductible - This is an amount of out-of-network covered expenses incurred each Calendar Year for which no benefits will be paid. The out-of-network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the out-of-network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

7.03 Network Family Deductible Limit - When you incur network covered expenses that apply toward the network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the network Calendar Year family deductible limit. Your network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the network family deductible limit in a Calendar Year.

7.04 Out-of-Network Family Deductible Limit - When you incur out-of-network covered expenses that apply toward the out-of-network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the out-of-network Calendar Year family deductible limit. Your out-of-network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the out-of-network family deductible limit in a Calendar Year.

7.05 Deductible Carryover - Under this feature, any covered expenses that you incur in the last three months of a Calendar Year that apply toward that year's network or out-of-network Calendar Year deductible will also count toward the following year's network or out-of-network Calendar Year deductible.

7.06 Copayment, Copay - This is a specified dollar amount or percentage of the negotiated charge required to be paid by you at the time you receive a covered service from a network provider. It represents a portion of the applicable expense.

7.07 Payment Provisions/Payment Percentage - This is the percentage of your covered expenses that the plan pays and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable deductibles have been met, your plan will pay a percentage of the covered expenses, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment

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percentage amounts for each covered benefit.

7.08 Maximum Out of Pocket Limit -The Maximum Out of Pocket Limit is the maximum amount you are responsible to pay for covered expenses during the Calendar Year. Once you satisfy the Maximum Out of Pocket Limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. The Maximum Out of Pocket Limit applies to both network and out-of-network benefits. This plan has an Individual Maximum Out of Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual Maximum Out of Pocket Limit, the plan will pay 100% of covered expenses for the remainder of the Calendar Year for that person. There is also a Family Maximum Out of Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the Family Maximum Out of Pocket Limit amount in the Summary of Benefits, the plan will pay 100% of covered expenses for the remainder of the Calendar Year for all covered family members.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan out-of-pocket limit. These include:

- Expenses applied toward a deductible;
- Charges over the recognized charge;
- Expenses to which a copayment is applied;
- Any covered expenses which are payable by Aetna at 50%,
- Expenses incurred for outpatient treatments, including any outpatient prescription drugs;
- Expenses incurred for mental disorder and alcoholism treatment expenses, substance abuse, and private duty nursing;
- Non-covered expenses;
  - ✓ Expenses for non-emergency use of the emergency room;
  - ✓ Expenses incurred for non-urgent use of an urgent care provider;
  - ✓ Certain other covered expenses (see list in the *Schedule of Benefits*), and
  - ✓ Expenses that are not paid, or precertification benefit reductions because a required precertification for the service(s) or supply was not obtained from Aetna.

7.09 Lifetime Maximum Benefit - The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit. The Lifetime Maximum Benefit applies to network and out-of-network expenses combined.

SECTION VIII

GROUP CONTINUATION COVERAGE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

8.01 COBRA Coverage, General Information - The following information about your right to continue your health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this SPD is intended to expand your

rights beyond COBRA's requirements. This is only a summary of COBRA continuation coverage rights. For additional information about your COBRA rights and obligations under the Plan and under federal law, you should contact BPA.

8.02 What is COBRA Coverage - COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to your employer and BPA, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event.

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

8.03 Who is Entitled to Elect COBRA? - If you are an employee, you will become a qualified beneficiary entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying event happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are the dependent child of an employee, you will become a qualified beneficiary entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct;
- your parents become legally separated or divorced; or
- you stop being eligible for coverage under the Plan as a "dependent child."

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If you have a newborn child or have a child placed with you for adoption while your COBRA continuation coverage is in effect, you have the right to elect coverage for such child if the Plan Administrator receives notice of that birth, adoption or placement for adoption *within 30 days* of its occurrence. A child born or placed with you for adoption while you are receiving COBRA continuation coverage will have the same COBRA rights as your spouse or dependents who were covered by the Plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, the child's continued coverage depends on the timely and uninterrupted payment of your COBRA payments.

The Family and Medical Leave Act of 1993 provides up to 12 weeks of unpaid leave for certain family and medical reasons (and up to 26 weeks if the leave is to care for a family member who is recovering from a serious illness or injury sustained in the line of duty during military service). If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

8.04 When is COBRA Coverage Available? - When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. Your employer is responsible for notifying BPA of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify your employer in writing within 60 days after the date of the qualifying event. You may be requested to provide evidence that a qualifying event has taken place, such as a judgment of separation or divorce or a death certificate. BPA's address is: 5800 Foremost Drive, S.E., Grand Rapids, MI 49549 (telephone: (800) 370-4349). **Failure to provide notice or information when required will result in the permanent loss of your COBRA rights.**

8.05 Electing COBRA Coverage - Once BPA receives timely notice of a qualifying event, COBRA continuation overage will be offered to each qualified beneficiary. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. The covered employee may elect COBRA continuation coverage on behalf of their spouse, and parents may elect continuation coverage on behalf of their children. You have 60 days after the date you receive the COBRA election notice to submit your COBRA election form. You must mail or hand-deliver the notice to your employer and/or BPA. Spoken, e-mail or faxed elections do not count. If you reject COBRA before the due date, you may change your mind as long as your submit an election notice before the due date.

It is important to remember that if an election is not made by or for a qualified beneficiary within the 60-day election period specified in the Plan's COBRA election notice, the qualified beneficiary will permanently lose his or her right to elect COBRA coverage.

Entitlement to Medicare. When you complete the Election Form, you must notify your employer if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify your employer of the date of your Medicare entitlement.

Which Plan Components May Be Elected? Qualified beneficiaries may be enrolled in one or more group

group health components (for example, Medical or Dental) of the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health components of the Plan under which he or she was covered on the day before the qualifying event. (For example, if a qualified beneficiary was covered under Medical and Dental on the day before a qualifying event, he or she may elect COBRA under the Dental component only, the Medical component only, or under both Medical and Dental.)

8.06 Length of COBRA Coverage - COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When the Qualifying Event is Death, Divorce, Legal Separation, or Child's Loss of Dependent Status. When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When the Covered Employee Becomes Entitled to Medicare Within 18 Months Before His or Her Termination of Employment or Reduction of Hours. When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event 36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction in hours.

When the Qualifying Event is a Termination of Employment or Reduction in Hours. Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

8.07 Extension of Maximum Coverage Period - If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your employer of a disability or a second qualifying event in order to extend the period of COBRA coverage.
Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability Extension of COBRA Coverage. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify your employer in a timely fashion, you and all of the other qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

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You Must Notify Your Employer of a Qualified Beneficiary's Disability by This Deadline. The disability extension is available only if you notify your employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction in hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction in hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.
In providing this notice, you must use the Plan's form entitled "Notice of Disability" which you can obtain from the employer or BPA. If the Plan's procedures are not followed or if the notice is not provided in writing to the employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

Second Qualifying Event Extension of COBRA Coverage. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available when a covered employee becomes entitled to Medicare.)

Deadline for Notice of Second Qualifying Event. The extension for a second qualifying event is available only if you notify your employer in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event" which you can obtain from the employer or BPA. If the Plan's procedures are not followed or if the notice is not provided in writing to the employer during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

8.08 Termination of COBRA Coverage Before the End of the Maximum Coverage Period - COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the Plan ceases to provide group health benefits; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a

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participant or beneficiary not receiving COBRA coverage (such as fraud).

Providing Notice When a Qualified Beneficiary Becomes Entitled to Medicare or Obtains Other Group Health Plan Coverage or Ceases to be Disabled. You must notify the employer in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability" which you can obtain from the employer or BPA.

If a disabled beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan of that fact within 30 days after the Social Security Administration's determination, using the Plan's form "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability" which can be obtained from the employer or from BPA.

8.09 Paying The Cost of COBRA Coverage - Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 % (or, in the case of an extension of COBRA coverage due to a disability, 150 %) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount for your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the employer indicated in Appendix C.

When you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the employer named in Appendix C if hand-delivered).

Claims will not be processed and paid until you have elected COBRA and made the first payment for it. If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. **You will not receive periodic notices of payments due for these coverage periods (that is, you will not receive a bill for your COBRA coverage). It is your responsibility to pay your COBRA premiums on time.**

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months. To be considered an "Assistance Eligible Individual" and get reduced premiums you: (1) must be eligible for

COBRA continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the COBRA coverage; (2) must be entitled to elect COBRA coverage because of an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009; (3) must not be eligible for Medicare; and (4) are not eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer. (Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.)

If you experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and you were offered but did not elect COBRA coverage, or if you elected COBRA coverage and then discontinued it, you may have the right to an additional 60-day election period.

Note that if you electing the ARRA premium reduction, you could be disqualified from the Health Coverage Tax Credit, which could be more valuable than the premium reduction. If you are eligible for the Health Coverage Tax Credit, you will have received a notification from the IRS.

If you earn more than $125,000 per year ($250,000 for married couples filing jointly), all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov. If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA COBRA premium reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

8.10 Keep The Plan Informed of Address Changes - In order to protect your family's rights, it is your responsibility to keep the Plan informed of any changes in your address or in the addresses of family members, and in the event of any changes in your family (such as births, deaths, legal separation or divorce, entitlement to Medicare, etc.) You should also keep a copy of any notice you send to the Plan for your records.

8.11 If You Have Questions - Questions concerning your Plan or your COBRA rights should be addressed to BPA, whose address is:

Benefit Plan Administrators (BPA)
5800 Foremost Drive, S.E.
Suite #207
Grand Rapids, Michigan 49546
(800) 370-4349
(616) 808-2898

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SECTION IX

CLAIM PROCEDURE AND GENERAL PROVISIONS REGARDING BENEFITS

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

9.01 Filing a Claim

(a) If you have a claim from a non-participating provider, contact your Employer or the Plan Administrator, BPA to obtain a claim form. A claim form which has been approved by the Health Insurance Association of American (HIAA) is acceptable to the Plan Administrator. Written proof of loss must be furnished to the PLAN and/or the Benefit Administrator on the approved claim form within two (2) years after the date the covered expense is incurred.
Benefits will not be paid until the Plan and/or the Benefit Administrator receives written documentation of the occurrence, nature and extent of the expense for which the claim is filed. Failure to furnish such documentation within the required time shall not invalidate nor reduce any claim if it was not reasonably possible to give documentation within such time, provided such documentation is furnished as soon after as reasonably possible.
Important note regarding late claims: The Plan will not honor, and no payment will be made for a claim which has not been received by the Plan within two (2) years following the date of service.

(b) The Benefit Administrator reserves the right to have a doctor examine the Member when it deems it reasonably necessary and there is a claim pending under the policy/plan.

(c) No action at law or in equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after written proof of the loss upon which claim is based has been furnished above. No such action shall be brought more than three (3) years after the expiration of the time within proof of such loss is required, or within three (3) years after the filing of a claim, if earlier.

(d) An assignment of benefits, authorizing the Administrator to make payment directly to the Provider, shall be signed by the employee Member. All payments will then be made directly to the provider, unless the covered Member then notifies the Administrator in writing to make payment directly to that covered Member.

9.02 Internet & Web Based Claims & Customer Service – "User Friendly" web based tools help CBT provide members with claims & benefit services designed to provide the "best in practice" health care. Both Aetna & Caremark bring a strong nationwide provider networks which are continuously updated, as well as state of the art chronic and disease case management. Prescription Benefit Management is accessed through CVS/Caremark websites.

If an eligible employee or covered dependent receives treatment outside of Michigan, the employee needs to only show his/her Aetna Identification Card. The provider will send the bill directly to Aetna.

The best and easiest way to access provider listings is via their websites:

Aetna www.aetna.com

CVS/Caremark www.cvscaremark.com

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9.03 Appeal of Denied Claim or Adverse Benefit Determination **-** Timing of Initial Notice of Benefit Determination by Plan

Urgent Care
Aetna/BPA will provide a response to the claimant not more than 72 hours after the receipt of the claim. If the claim is incomplete, Aetna/BPA will notify the claimant within 24 hours after the receipt of the claim. The claimant will then have 48 hours to provide the missing information. BPA will have 48 hours to make a decision after the earlier of its receipt of the missing information or the end of the period for the claimant to provide the missing information.

Concurrent Care
Any termination of an ongoing course of treatment shall be treated as an adverse benefit decision. Aetna/BPA will notify the person affected in the form of a notice of adverse benefit determination sufficiently in advance of the termination to allow time for the person to appeal before the benefit is terminated.

Pre-Service Claims (Non-Urgent)
Aetna/BPA will provide a benefit determination up to 15 days after receipt of the claim. This period of time may be extended an additional 15 days by Aetna/BPA if, for reasons beyond its control, a determination cannot be made within the first 15 days, and Aetna/BPA will notify the claimant of this within the first 15 day period, including the reason for the extension. If the reason is that the claim is missing information, the claimant has 45 days from the date of this notice to provide the missing information.

Post-Service Claims
Aetna/BPA will provide a benefit determination no later than 30 days after receipt of the claim. This period of time may be extended by an additional 15 days by Aetna/BPA if, for a reason beyond its control, a determination cannot be made within the first 30 days, and Aetna/BPA will notify the claimant of this within the first 30 days including the reason for the extension. If the claim is incomplete, the claimant has 45 days from the date of the notice to provide the missing information.

Notice of Adverse Benefit Determination - Adverse benefit determinations are anything other than granting and paying for the benefit.

Appeal by Claimant
The claimant has 180 days following receipt of the notification to appeal an adverse benefit determination on his claim. The claimant can appeal through his representative. The decision-maker on appeal will not give any deference to the initial adverse determination and, where a medical decision is involved, will rely on health care professional(s) with expertise in the field in question who will not be the same person(s) who made the determination on the initial claim. A claimant who appeals will be allowed the opportunity to submit written comments, documents, records and other information relating to the claim. Aetna/BPA will provide reasonable access to and copies of all documents, records and other information relevant to the appeal. All appeals are overseen by OFIR.

Plan Response to Appeals
Urgent Claims – Aetna/BPA will respond not later than 72 hours after receiving the appeal.
*Pre-Service Claims – Aetna/*BPA will respond not later than 15 days after receiving the appeal.
Post–Service Claims – Aetna/BPA will respond not later than 30 days after receiving the appeal.

The Plan's response to your appeal will be in writing, and it will give specific reasons and reference to applicable Plan documents if the appeal is denied.

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

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

9.06 Subrogation - If a Member incurs expenses on account of bodily injury or sickness, caused by negligence or wrong of a third party, and benefits are payable under this Plan, the Member will receive the benefits, provided that, if there is recovery by the Member or any dependents or a personal representative from the third party, or his/her personal representative, whether in full or in part, and whether by judgment, settlement or otherwise, on account of such bodily injury or sickness, the Member shall reimburse the Plan to the extent of the total amount of such benefits paid under this Plan. The Plan's subrogation and reimbursement rights shall apply on a priority basis and shall apply to all amounts recovered regardless of whether or not such amounts are characterized or described as medical expenses. By accepting benefits from the Plan, the Member acknowledges that the proceeds of any recovery described above shall be held in constructive trust for the Plan and grants to the Plan an equitable lien on the proceeds received by or payable to the Member. The Member shall be solely responsible for paying all legal fees and expenses in connection with any recovery, and the Plan's subrogation rights shall not be reduced by any such legal fees and expenses unless the Plan, in its sole discretion, agrees in writing to reduce its subrogation right. The Member shall cooperate with and assist the Plan in exercising its subrogation rights, and the Plan may require the Member to execute a subrogation and reimbursement agreement as a condition to receiving benefits from the Plan.

9.07 Privacy of Information - Each Member covered under this Plan hereby authorizes physicians, hospitals, and other providers of service to furnish the Plan's designee, Aetna and Benefit Plan Administrators, Inc. (BPA), upon request, information relating to services for which the covered Member is or may be entitled to coverage for under this Plan. Physicians, hospitals and other providers of services are hereby authorized to permit Aetna and BPA to examine their records with respect to such services.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes standards for the privacy and security of health information. Protected Health Information ("PHI") under HIPAA includes any health information which can be identifiable with an individual. The Plan will use and disclose PHI only as permitted or required by HIPAA and the Privacy Regulations implementing HIPAA. Appendix E contains a Notice concerning the Plan's Privacy Practices.

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

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

9.10 Questions About Benefits - CBT has contracted with Benefit Plan Administrators, Inc. (BPA), to administer the Plan. Only employees of BPA are qualified to answer questions regarding benefits, eligibility, and other terms and conditions of the Plan. Any questions about benefits or coverage can be directed to BPA at the following location:

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Benefit Plan Administrators, Inc. (BPA)
Suite #207
5800 Foremost Drive, S.E.
Grand Rapids, Michigan 49546
Telephone number(s): (888) 808-0408

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

As a requirement by the Michigan Office of Insurance and Investment Regulation, the Plan Administrator must provide the following information. The Plan Administrator:

(i) Does not guarantee or warrant this is an insured plan. The Employer assumes all responsibilities for insuring benefits on behalf of Members covered by the plan(s).

(ii) Does not insure, reinsure, or fund this benefit plan. Should the Plan Sponsor elect not to reinsure this plan, and ultimately not pay (fund) benefit expenses which are eligible for payment under the plan for any reason, the Members covered by the plan may be liable for those expenses.

(iii) Merely processes claims and does not insure the eligible expenses of the Plan. The Administrator does not guarantee Members covered under the plan that eligible expenses will be paid.

(iv) Will promptly process complete and proper claims submissions for benefits made by Members covered by the plan. In the event there are delays in processing claims, the Members covered by this plan shall have no greater rights to interest or other remedies against the Benefit Administrator than as otherwise afforded by law.

9.11 Agent for Service of Legal Process - The agent for service of legal process is
Mr. Andrew Nickelhoff,
Sachs Waldman P.C.
1000 Farmer, Detroit, MI 48226.

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

(a) When you write to the BPA Office, please be sure to provide your name and Social Security number in your letter. If you call, please be sure to have your Social Security number handy.

(b) Notify your Employer, and the BPA Office within 30 days after the date you gain or lose a Dependent (spouse or child) for any reason, for example, due to divorce, separation, death, or age, and as soon as possible (no later than 60 days) after you or your Dependents (spouse or child) lose eligibility for coverage under Medicaid or a children's health insurance program (CHIP) or after an you or your Dependents become eligible for government premium assistance under Medicaid or CHIP.

(c) If you or one of your Dependents becomes eligible for Social Security benefits and/or Medicare coverage, you must send a copy of the Social Security Award Letter and/or Medicare Card to your employer and the BPA Office immediately.

Notify BPA immediately if you change your home address.

9.13 Interpretation Of Plan: The Plan Administrator and/or Underwriter has sole authority to interpret and apply the provisions of this Plan, and to determine eligibility for coverage and benefits. The decisions of the Plan

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Administrator and/or Underwriter are final and binding on all parties. A covered member always has the right to file an appeal according to the provisions as provided in Section 9.03.

9.14 Source of Contribution: This Plan is funded by contributions and premiums of the Employer and is established and maintained for the sole purpose of providing benefits to eligible Member Employees and their covered Dependents. Benefits of this Plan are fully insured and are provided through insurance policies secured by the CBT.

9.15 Amendment or Termination of the Trust Fund: The CBT may amend the Trust Document at any time. Although the CBT anticipates that the Trust will remain in effect, it reserves the right to terminate the Trust at any time. Any funds remaining in the Trust Fund at termination will be distributed for the benefit of Members in a manner determined by CBT.

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