

UAW GM Legal Services

Where To Find The Answers To Your Questions

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SUMMARY OF BENEFITS

The Summary of Benefits provides a general description of your benefits. It does not list all benefits included under the Plan. The Plan contains limitations and restrictions which are described in the Booklet and could reduce the benefits payable under the Plan. See the detailed description to determine what expenses are covered and what benefits will be payable.

GREAT-WEST PPO MEDICAL BENEFITS

Copay Amount for Network Services

Office Visits	\$10.00
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Deductible

The calendar year deductible applies to all covered expenses except:

- expenses payable at 100%
- expenses subject to a copay
- expenses for outpatient x-rays and lab tests
- expenses for services, including surgery, provided in a Network Doctor's office

Individual Calendar Year Deductible	\$100.00
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Family Calendar Year Deductible	\$200.00
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Percentage Payable after any applicable Deductible or Copay

Pre-admission Testing	100%
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Facility charges by a Childbirth Center	100%
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Home Health Care	100%
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Skilled Nursing facility	100%
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Hospital	100%
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Physician charges for Hospital care and Surgery	100%
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X-ray and lab tests	100%
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Emergency Room care	100%
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Outpatient Surgery, including surgery performed in a Doctor's Office	100%
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Hospice Care	100%
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Preventive Care	100%
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\$500.00 Accident Expenses for treatment received solely as a result of an Accidental Injury. Injury must have occurred while covered under the Plan. Expenses must be incurred within 90 days after the accident.	100%
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Office Visits	
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- Network	100%
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- Services outside the PPO Network Area	80%
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- Non-network	80%
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Outpatient Mental Health Conditions Treatment	
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- Network	80%
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- Non-network	50%
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Inpatient Mental Health Conditions Treatment	
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- Network	100%
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- Non-network	80%
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Outpatient Chemical Dependency Treatment	
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- Network	100%
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- Non-network	80%
Inpatient Chemical Dependency Treatment	
- Network	100%
- Non-network	80%
Other Covered Expenses	80%

Individual Breakpoint	\$2,000.00
Family Breakpoint	\$4,000.00

Calendar Year Benefit Maximum

Hospice Care \$5,000.00 each 6 month benefit period and 30 days inpatient care

Home Health Care up to 100 visits

Skilled Nursing Facility 100 days

Preventive Care (mammograms are excluded from maximum) \$200.00

Inpatient Treatment of Mental Health Conditions 30 days

Inpatient Treatment of Chemical Dependency 30 days

Outpatient Treatment of Mental Health Conditions 52 visits

Outpatient Treatment of Chemical Dependency 52 visits

Spinal Adjustment Treatment \$1,000.00

Lifetime Benefit Maximum

TMJ Treatment \$1,500.00

Maximum Benefit for all Covered Expenses

Lifetime benefit per Member Unlimited

PRESCRIPTION DRUG BENEFITS

Prescription Drugs 100% after \$5.00 copay

Mail Order Drug Program 100% after \$1.00 copay

VISION BENEFITS

Calendar Year Deductible None

Percentage Payable

Eye examinations 100%

Eyeglass lenses and frames or contact lenses 100%

Benefit Maximum (per 12-month period)

Eye examinations \$20.00

Eyeglass lenses and frames or contact lenses

- Single vision lenses \$40.00

- Bifocal lenses \$46.00

- Trifocal lenses \$50.00

- Lenticular lenses \$64.00

Lifetime Benefit Maximum

Contact lenses prescribed for medical reasons \$120.00

LIFE INSURANCE BENEFITS

All Employees \$10,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The amount of AD&D Benefit that an Employee may receive is based on a Principal Sum. The amount of the Principal Sum is equal to the amount of Standard Life Insurance.

AD&D Benefit for the Loss of:

Amount Payable

Life	Principal Sum
Both hands or both feet or sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot and sight of one eye	Principal Sum
One hand or one foot	1/2 of Principal Sum
Sight of one eye	1/2 of Principal Sum

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT

The amount of an Employee's Life Insurance and AD&D Benefit in effect at the time the Employee reaches age 70 will reduce by 50% at age 70.

NOTICES

■ **Women's Health and Cancer Rights Act**

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

- all stages of 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 physical complications to produce a symmetrical appearance, including lymphedema.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

■ **Notice Required for Residents of Texas/Aviso Para Residentes Del Estado De Texas**

**GREAT-WEST LIFE & ANNUITY
INSURANCE COMPANY
EXECUTIVE OFFICES -
8505 EAST ORCHARD ROAD
GREENWOOD VILLAGE, COLORADO 80111**

**NOTICE REQUIRED FOR RESIDENTS OF TEXAS
AVISO PARA RESIDENTES DEL ESTADO DE TEXAS**

IMPORTANT NOTICE

To obtain information or make a complaint

You may call Great-West's toll-free telephone number for information or to make a complaint at

1-800-537-2033

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance P.O. BOX 149104 Austin, TX 78714-9104 FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Great-West first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR PLAN

This notice is for information only and does not become a part or condition of the attached document.

■ Notice Required for Residents of Wisconsin

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

P.O. BOX 1080

DENVER CO 80201

(303) 737-3000

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

Office of the Commissioner of Insurance

Complaints Department

P.O. BOX 7873

Madison, WI 53707-7873

AVISO IMPORTANTE

Para obtener informacion o para someter una queja

Usted puede llamar al numero de telefono gratis de Great-West's para informacion o para someter una queja al

1-800-537-2033

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas P.O. BOX 149104 Austin, TX 78714-9104 FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Great-West primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

UNA ESTA AVISO A SU POLIZA

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

or you can call 1-800-236-8517 outside Madison or 266-0103 in Madison, and request a complaint form.

IF YOUR PLAN INCLUDES A PREFERRED PROVIDER ARRANGEMENT (PPO), you may resolve your problem by taking the steps outlined in your PPO grievance procedure. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** as noted above.

INTRODUCTION

■ About This Plan

UAW GM LEGAL SERVICES PLAN (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of JANUARY 1, 2003, the benefits described in this booklet constitute the benefits available under the plan and are referred to collectively in this booklet as the Plan. The Plan will be maintained pursuant to the terms of this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

If on the date shown above you are not Actively at Work, refer to Will My Coverage Change? within the section WHEN COVERAGE BEGINS & ENDS for details as to when a change in coverage will become effective.

Some of the benefits that form a part of the Plan and are described in this booklet are fully insured by Great-West Life & Annuity Insurance Company (Great-West), 8505 E. Orchard Road, Greenwood Village, CO 80111. Others are self-funded by the Employer.

Defined terms are capitalized throughout this booklet. These terms have a special meaning with respect to the coverage outlined in the booklet and are defined in the Glossary.

Insured Benefits

Life and AD&D Insurance

For insured benefits, this booklet becomes your certificate of insurance only if you complete the appropriate application forms and are approved for coverage by Great-West.

Great-West has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

Self-Funded Benefits

Medical, Prescription Drug and Vision Benefits

The Plan Administrator has complete authority to control and manage the Plan. For initial claim determination, the Plan Administrator has full discretion to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Great-West as the appeals fiduciary. Great-West will have full discretion and authority to interpret the Plan and to determine whether a claim should be paid or denied on appeal and according to the provisions of the Plan as set forth in this booklet.

The Employer is fully responsible for the self-funded benefits. Great-West processes claims and provides other services to the Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

Plan Modification/Termination

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee or Dependent will determine who is eligible for coverage under the Plan.

Coverage will begin after you have satisfied any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution; and
- For Life and AD&D Insurance, be Actively at Work on the eligibility date.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent. If you have already elected Dependent coverage, any new Dependents will be covered automatically.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth and evidence of commencement of adoption proceedings; and
- For any other adoptive child, from the date of placement and evidence of commencement of adoption proceedings.

If your Employer receives a request to add your Dependent pursuant to a medical child support order, the Employer will determine whether the order is qualified. If the order is determined to be a Qualified Medical Child Support Order (QMCSO) and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing QMCSO.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

Medical, Prescription Drug and Vision Benefits

If you are a late applicant, contact your Plan Administrator for details on when your coverage will begin.

For Medical, Prescription Drug, and Vision benefits, a Member is *not* a late applicant if:

- You did not apply for coverage within 31 days of the eligible date because the Member was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
 - Exhausting the maximum period of COBRA coverage; or
 - Loss of eligibility for the other plan's coverage due to legal separation, divorce, death of a spouse, termination of employment or reduction in the number of hours of employment; or
 - Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.

- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the court ordered date.
- You acquire a new Dependent, coverage will start:
 - In the case of marriage, on the date of marriage.
 - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

Life and AD&D Insurance

Late applicants must provide Great-West with Proof of Good Health at their own expense. Coverage for a late applicant will begin on the date Great-West approves Proof of Good Health.

■ What If I Was Covered for Health Benefits Under the Employer's Prior Plan?

A Member who had similar coverage under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan effective date. Any waiting period under this Plan will be reduced by the part of the waiting period that had been satisfied under the prior plan. "Health benefits" mean medical, prescription drug and vision benefits.

If a Member was on COBRA or any other continuation coverage or extension of benefits under the prior plan and that plan terminated, coverage will be provided for that Member until the earlier of:

- The date on which coverage would end under the terms of the Plan; or
- The last day of the period for which coverage would have been provided had the prior plan not terminated.

If a Member was covered under any extension of benefits under the prior plan, the benefits provided under this Plan will be the same as those provided by the prior plan, less any amount paid under the prior plan.

If you were on Family and Medical Care Leave on the effective date of this Plan and you were covered under the Employer's prior plan on the date of its termination, then you will become covered for the benefits provided under this Plan as of its effective date.

Deductible and Breakpoint Credits

Any amount a Member has already paid toward the calendar year medical deductible under the prior medical plan will be applied to this Plan's calendar year medical deductible.

Any benefit maximums under this Plan will be reduced by the amount paid under the prior plan in the calendar year in which your Employer transfers claims processing to Great-West.

Any amount of covered expenses a Member has already used to satisfy any calendar year breakpoint under the prior medical plan will be applied to this Plan's calendar year breakpoint.

Special Benefits for Pre-Existing Conditions

These benefits apply if a Member would not be eligible for coverage under the Plan because of the pre-existing conditions limitation and is not eligible for benefits under the prior plan because expenses were incurred after termination of that plan.

The amount of benefits will be the lesser of the amount that would have been paid under the prior plan if it had stayed in force and the amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time a Member has already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class on the date that the Member's class status changes.

For Life and AD&D Insurance, if you are an active Employee and you are not Actively at Work when either of these changes occurs, the change in your coverage will not take place until you return to work with the Employer for one full day. This does not apply to Medical, Prescription Drug, and Vision Benefits.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.
- The date Loss of Residence occurs.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends; or
- Loss of Residence occurs; or
- The date your Dependent is no longer eligible for benefits; or

- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

■ **Can I Continue or Convert My Coverage If I Become Ineligible?**

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

Continuation of Life Insurance during an Illness, Approved Leave of Absence or Temporary Layoff

If your Service ends due to Illness, Life Insurance will continue for 12 months after your Service ends.

If your Service ends due to approved leave of absence or temporary layoff, Life Insurance will continue for 31 days after the date your Service terminates.

Your coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

There is no continuation for AD&D benefits.

Continuation of Coverage during Family and Medical Care Leave

If the Employer approves your Family and Medical Care Leave, coverage under the Plan will continue subject to the terms of the Collective Bargaining Agreement between the Employer and Employee during the portion of your leave covered by the Family Medical Care Leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. However, a COBRA qualifying event does not occur unless you do not return to work on the date you are scheduled to return from your FMLA leave. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about Family and Medical Care Leave, see the Plan Administrator.

Continuation under COBRA for Medical, Prescription Drug and Vision Coverage

A Member may be eligible to continue coverage under COBRA. Qualifying events determine eligibility for COBRA coverage and the length of continuation.

If you lose your coverage due to a reduction in your hours of employment, or termination of your Service for any reason except gross misconduct, this is a COBRA qualifying event. For a covered Dependent, a qualifying event includes termination of your Service, reduction in your hours of employment, your becoming entitled to Medicare, and your death, divorce or legal separation. The date a Dependent no longer meets the definition of Dependent is also a qualifying event.

When the qualifying event is termination of your Service or a reduction in your hours of employment, COBRA coverage may be extended for a Member who qualifies for Social Security disability benefits. However, the Member's disability must have existed on the date of the qualifying event or have begun within the first 60 days of COBRA coverage.

When a qualifying event occurs, the Employer or a representative of the Employer must give you the necessary COBRA election form. You must complete and return this form to the Employer or his or her representative within 60 days of the later of the date the Member loses coverage or the date the Member receives the COBRA election forms.

If a Member receives a Social Security disability determination, the Member must notify the Employer or his or her representative within 60 days of the determination and before the end of the initial 18 month COBRA coverage period in order to extend COBRA coverage to 29 months.

You are also eligible for COBRA if you experience an increase in your contribution for coverage as a result of a qualifying event. If you have questions about COBRA, see the Plan Administrator.

If you are a resident of Tennessee, you may be entitled to have the State of Tennessee pay the contribution for your on-going health coverage. For more information, contact your local Tennessee Department of Human Services.

Extension of Medical and Prescription Drug Benefits

A Member who is Totally Disabled on the date he or she becomes ineligible for continuation of coverage or continuation under COBRA may still be eligible for extended benefits for the disabling condition only. These benefits are extended:

- During the course of that Total Disability.
- Under the same benefit provisions as if coverage had not ended.
- Upon termination of the Member's coverage under this Plan, for 3 months, as long as this Plan is still in force.

Benefits for prescription drugs will be payable under the Medical Benefit and not the Prescription Drug Benefit.

You do not have to pay for extended benefits.

Conversion of Life Insurance Benefits

If all or part of your group term life insurance ends, you may apply for an individual life insurance policy.

Proof of Good Health is not required. You must apply for the life conversion coverage within 31 days after your life insurance coverage ends.

The policy will be one of Great-West's standard conversion policies and will not contain a disability benefit or an accidental death benefit. The amount of coverage chosen can never be more than your current amount of insurance. The amount of the premium will depend on your age and class of risk.

You are allowed 31 days to apply for the individual policy. If you die within this period, your beneficiary will receive a death benefit. The amount of this benefit will be the maximum amount of group term life insurance which you would have been eligible to convert under this provision.

However, if the amount of your insurance had been reduced during this 31-day period because of age or retirement, the death benefit will be the amount of your group term life insurance before the reduction. This death benefit is payable even if you had not applied for an individual policy.

Employee Conversion of Life Insurance Benefits

If the group policy is still in force, you may convert all or part of your insurance to an individual policy if your coverage ends. If your coverage reduces due to age or retirement you may convert up to the amount of the reduction.

If the group policy is terminated or amended you may convert your life insurance if all or part of your coverage ends. However:

- You must have been insured under the group policy for at least five consecutive years; and
- The amount of the individual policy will be the lesser of \$2,000.00 and the current amount of your group term life insurance.

If your insurance is being continued under the disability benefit, you may convert your coverage if your coverage ends or reduces due to age or retirement. You may convert this coverage even if the group policy is not in force.

Conversion of AD&D Benefits

Conversion coverage is not available for AD&D benefits.

■ **Can Coverage Be Reinstated?**

If your coverage ended because of termination of your Service, it will be reinstated subject to the terms set within the Collective Bargaining Agreement between the Employer and Employee.

On the date your coverage is reinstated, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

Coverage for a Military Reservist who returns from active duty will be reinstated as required under the Uniformed Services Employment & Re-employment Rights Act.

Coverage for a Member whose coverage ended due to Loss of Residence will be reinstated:

- for an Employee, on the day after completing 30 consecutive days of Work in the United States;
- for a Dependent, on the day after completing 30 consecutive days residence in the United States.

The Member must return to the United States within three months of the date the Loss of Residence occurred to be reinstated.

Coverage will be on the same basis as that being provided for any other active Employee and his or her Dependents on the date coverage is reinstated. However, any restrictions on the coverage that were in effect before reinstatement will continue to apply.

GREAT-WEST PPO MEDICAL BENEFITS

■ **How Does the Plan Work?**

The PPO plan includes a nationwide network of Hospitals and Doctors and a Medical Management Program. Care given by network providers is payable at a higher level than care given by non-network providers.

A Member can call Member Services for the names of network providers or access the on-line directory at www.onehealthplan.com. Network Doctors will submit Member's claims and take care of getting Medical Management approval when necessary.

Members who use a non-network Doctor will need to file their own claim and make sure treatment is approved by Medical Management.

Members who use a non-network provider may reduce their out-of-pocket expenses by choosing a provider participating in the MultiPlan network. MultiPlan is a supplemental network available to Members who choose to use a provider outside the network. Call Member Services for the names of providers who are participating in the MultiPlan network, or access www.multiplan.com. MultiPlan providers are considered non-network providers under this Plan, therefore, the Member is responsible for pre-treatment approval for hospital admissions and surgery outside the Doctor's office. Please refer to the Summary of Benefits.

Out of Town Care

If a Member is out of town and needs non-emergency care, the Member should contact Member Services for help in locating a network provider. Since the PPO network is nationwide, the Member may be able to see a network provider and receive a higher level of benefits.

If a Member is outside the PPO network area, benefits will be payable as shown on the Summary of Medical Benefits.

Emergency Care

If emergency care is needed, go to the nearest medical facility. Coverage for emergency care is available 7 days a week, 24 hours a day. Members are not required to request pretreatment authorization prior to receiving care in an emergency room.

Great-West administers a prudent layperson emergency policy. You are experiencing an emergency if you have a sudden onset of acute symptoms and believe that if you don't get immediate care, it may result in serious jeopardy to your health. Some examples are chest pain, difficulty in breathing and uncontrolled bleeding.

Special Services

Some services are payable at the network level even when not performed by a network provider. These services include:

- X-rays or lab tests performed while inpatient in a network Hospital.
- Services of an anesthesiologist or assistant surgeon when the surgery is performed by a network Doctor in a network Hospital.

Medical Management (MM) Program

One Health Plan (ONE) is the entity that reviews and authorizes urgent, concurrent and prospective medical services and prescription drugs for Members covered under the Plan. The Member's Doctor must call Medical Management (MM) for pretreatment authorization.

Certain services require pretreatment authorization including, but not limited to, inpatient hospital care, surgery outside the Doctor's office and prescription drugs that exceed a recommended dosage or need to be reviewed for medical necessity based on recommendations from medical experts and the FDA. If a Member uses a non-network Doctor, the Member must make sure that treatment is approved by Medical Management. For a complete list of services that require pretreatment authorization, call Member Services. The MM telephone number is on the ID card.

If a pretreatment request does not follow ONE's procedures, ONE will notify the provider of the established procedures no later than 5 days after receipt of the request.

Medical Management will determine:

- The medical necessity of the care;
- The appropriate location for the care to be provided; and
- If admitted to a Hospital, the appropriate length of stay.

Care received in an emergency room does not require pretreatment authorization. However, if hospitalization or surgery is required because of an emergency, the Member's Doctor must call MM within two days after care is given.

Medical Management will review and render an authorization determination as described below.

• Urgent Care Requests

For an urgent care request, MM will notify the Member and the provider of the authorization decision:

- no later than 24 hours after receipt of a request involving concurrent care, if the request is made at least 24 hours prior to the expiration of the previously approved care; and
- no later than 72 hours after receipt of any other urgent care request.

If MM does not have all the information needed to process an urgent care request, MM will notify the Member or provider within 24 hours after receipt of the request and give details as to what additional information is required. The requested information should be provided within 48 hours or the authorization request may be denied. MM will notify the Member and provider of the authorization decision within 48 hours after the requested information has been received.

MM will provide either verbal or written notice of the decision. When verbal notice is provided, a written notice will be sent within 3 days.

- **Non-urgent Care Requests**

For a non-urgent care request, MM will notify the Member and provider of an authorization decision no later than 15 days after receipt of the request. If an authorization decision cannot be made within the 15-day period, an extension of up to 15 days may be requested. If additional information is needed, the Member or provider will be notified within the initial 15-day period and given details as to what information is required. The requested information should be provided within 45 days after receipt of the request or the authorization request may be denied.

An authorization decision will be made no later than 15 days after MM receives the requested information, unless the Member or provider agrees to a voluntary extension of time.

Medical Management will send the Member and the provider written notice of all authorization determinations.

If previously authorized benefits are reduced or terminated, MM will send notice of this decision *prior* to any reduction or termination of benefits.

If a Member receives notice of an adverse determination, in whole or in part, the Member or the Member's Authorized Representative can appeal the decision.

An **Authorized Representative** means a person or health care provider authorized in writing by the Member to represent the Member's interests for claim submission, pretreatment and appeal requests. The Member's health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

Adverse determination means a determination of non-approval, in whole or in part, of a pretreatment or claim payment request.

If the MM decision is an adverse determination, the Member will be sent written notice that will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the request and why the information is needed, the appeal procedures and time limits, including procedures and time limits for urgent care appeals, and the Member's right to bring civil action under ERISA section 502(a).

The adverse determination notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge; and
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

Medical Management Case Management Program

The MM Program also provides Hospital discharge planning and identifies patients who might benefit from the Case Management Program.

The Case Management Program (CM) helps Members with serious illnesses manage their health care. The goal of the CM program is to develop alternative treatment plans that will help these Members obtain the type of care needed *outside* of a Hospital setting. Members who choose to participate in this program are assigned a case manager to help coordinate care.

If a Member and the Member's Doctor decide that the recommended alternative treatment plan is right for the Member, it will be covered on the same basis as the care and treatment for which it is substituted. This will be the case even if the alternate treatment plan includes care that is not otherwise covered under the Plan.

Appeal of Medical Management Decision

Appeal of a Medical Management decision should be requested within 180 days after receipt of an adverse determination. You have the right to review and/or request copies of relevant documents, free of charge, and to submit written comments, documents and issues.

One level of appeal must be completed for appeals involving urgent care and two levels of appeal must be completed for all other appeals involving a MM adverse determination, before a Member may bring civil action under ERISA for an adverse determination. (See Statement of ERISA Rights in the CLAIMS & LEGAL ACTION section of the booklet.) The appeal review will consider written comments, documents and any other information submitted by the Member, Authorized Representative or Doctor, regardless of whether the documentation was reviewed as part of the initial determination.

- **Level I Appeal**

The first appeal level is an internal review by Great-West, acting as the fiduciary for appeals. Upon receipt of an initial appeal of a denied request for medical services, ONE will assign the review to a board certified Physician Reviewer who is in the same or similar specialty that typically manages the service under review and *who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination.*

The Member and the Authorized Representative or provider will be sent written notice of an appeal determination:

- no later than 72 hours after receipt of an appeal involving urgent care; and
- no later than 15 days after receipt of an appeal involving non-urgent care; and
- no later than 30 days after receipt of a request for authorization of services that have already been provided.

If the appeal decision upholds an adverse determination, and you decide to appeal the decision, you may proceed to Level II. For appeals involving urgent care, Level II is voluntary.

- **Level II Appeal**

If the first level internal review denies authorization, in whole or in part, a second level appeal review may be requested. The second level appeal is an external review by an independent review entity and is binding on the Plan. The written request for external review must be submitted to ONE Health Plan within 60 days after receipt of the first level appeal determination. An external review will be provided at no cost to the Member.

A Doctor or a group of Doctors in the same or similar specialty that typically manage the service under review and who is not affiliated with ONE Health Plan will conduct the external review.

The Member and the provider will be sent a written notice of the external review determination:

- no later than 15 days after receipt of the second level appeal request for preauthorization of services; and
- no later than 30 days after receipt of the second level appeal request for authorization of services that have already been provided.

If the external review results in a denial of the requested service, the Member has the right to bring civil action under ERISA section 502(a).

Members will be sent written notice of an adverse determination upon completion of a Level I appeal and upon completion of a Level II appeal. The notice will include:

- the reason(s) for the determination;
- reference to the Plan provision(s) on which the determination is based;
- the Member's right to review and request copies of all relevant documents, free of charge;
- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge;
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge;
- that the Member may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and the state insurance regulatory agency; and
- the Member's right to bring civil action under ERISA section 502(a).

Appeal of an adverse determination involving urgent care may be submitted either orally or in writing and will be expedited by ONE.

Calendar Year Deductible and Copay

A calendar year deductible is the amount of covered medical expenses that must be satisfied before the Plan begins to pay benefits.

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the deductible for that year will also be applied to the deductible for the next calendar year.

A copay is an amount a Member pays for care at the time of service.

Allowable Covered Expenses

All medical benefits are subject to allowable covered expense guidelines.

Network providers have agreed to a set fee schedule. Members are not responsible for expenses over the scheduled amount for covered services. Members are responsible for any applicable copays, deductibles, and coinsurance.

For non-network providers, the allowable covered expense is determined by usual and customary charge guidelines. The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a provider and the fee usually charged by other providers in the same geographical area for these services and supplies. The Member must pay any amount over usual and customary charges.

■ What's Covered?

The Summary of Medical Benefits located in the front of the booklet shows the payment percentage, deductible and copay amounts applicable to various covered expenses. Any benefit maximums applied to specific covered expenses and calendar and lifetime benefit maximums for *all* covered expenses are also shown on the Summary of Medical Benefits.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services. This amount is in addition to any deductible or copay amounts.

Services must be Medically Necessary as defined in the Glossary. Unless otherwise noted for a particular service, services must be required as a result of symptoms of illness. Expenses are covered only if incurred while the Member is covered for these medical benefits.

Hospital Care and Surgery

The Plan covers semi-private room and board and ICU expenses as well as other inpatient and outpatient services, supplies and Doctor's charges. Hospital and Doctor charges for infant care through the first seven days of life are covered if you have elected Dependent coverage.

Skilled Nursing Facility

The Plan covers care in a licensed skilled nursing facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and the Member must continue to show functional improvement.

Coverage is limited to the usual charge of the facility for semi-private care. This amount includes room and board and all other services.

Office Visits

The Plan covers most services and supplies in a Doctor's office. X-rays and lab tests ordered or performed during an office visit are considered separate from the office visit and are subject to the payment percentage as shown in the Medical Summary of Benefits.

Certain procedures, such as surgery in a Doctor's office, are considered separate from the office visit. These expenses are subject to the payment percentage shown in the Medical Summary of Benefits.

Preventive Care

The Plan covers periodic physical exams by a Doctor for a Member who is at least eight days of age. This includes x-ray and lab services if part of the annual physical exam, necessary immunizations and booster shots.

The Plan covers an annual pelvic exam, Pap smear and mammogram.

Benefits are payable up to the maximum shown in the Summary of Benefits. Mammograms are excluded from the calendar year maximum.

Preventive care x-ray and lab tests will be payable under the Preventive Care payment percentage as shown in the Medical Summary of Benefits.

Reconstructive Surgery following a Mastectomy

The Plan covers reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications related to all stages of mastectomy, including lymphedemas.

Treatment is to be determined by the attending Doctor, in consultation with the patient. Benefits will be payable on the same basis as for any other surgery covered under the Plan.

Other Reconstructive Surgery

The Plan covers reconstructive surgery when the primary purpose is to improve function of the underlying structures or to restore large skin defects due to port wine stain. Surgery to correct significant congenital defects is covered only if the defect interferes with bodily function (not psychological function). Reconstructive surgery performed as a result of trauma or disease is covered when reconstruction begins within one year of the trauma or illness (except for reconstructive surgery as a result of a mastectomy). Subsequent surgical reconstructive procedures integral or linked to the covered reconstruction, that cannot be performed within the year due to medical considerations, may be covered more than one year later, but only if the planning for these procedures (as noted in the Member's medical records) takes place within one year of the trauma or illness.

Maternity Coverage

The Plan includes a Maternity Assessment Program. Within the first 12 weeks of pregnancy, call the Member Services number on the ID card to talk with a registered nurse trained in maternal and child health care.

The Plan covers prenatal, childbirth and postnatal care. Coverage for you and your baby, if dependent coverage is elected, includes a Hospital stay of 48 hours following a normal vaginal delivery and 96 hours following a C-section. The 48/96 hours begin following delivery of the last newborn in case of multiple-births. When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission. The Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for early discharge is made by the attending Doctor in consultation with the mother.

Pre-authorization is not required for the 48/96-hour Hospital stay. However, authorization is needed for a longer stay than as described above.

Family Planning

The Plan covers tubal ligations and vasectomies and infertility testing.

Treatment of TMJ and Related Disorders

The Plan covers treatment of temporomandibular disorders and craniofacial muscle disorders.

Treatment of Mental Health Conditions and Chemical Dependency

The Plan covers inpatient and outpatient treatment of mental health conditions, alcoholism, drug addiction and other chemical dependency.

Spinal Adjustment and Treatment

The Plan covers expenses for services related to spinal adjustment.

Home Health Care

The Plan covers home health care visits when services are provided by a licensed home health care agency. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The Member must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time.

Hospice Care

The Plan covers hospice care if prescribed by a Doctor and the Member's life expectancy is six months or less. For pre-death and bereavement counselling, up to \$200 (combined for covered person and family members) will be covered.

Other Medical Services and Supplies

The Plan covers:

- Non-disposable medical equipment appropriate for use within a Member's home. Covered equipment must be able to withstand repeated use and be used to treat an Illness. Replacement of equipment is covered only when required as a result of normal usage.
- Nursing services.
- Ambulance services.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.
- Custom-designed orthotics when prescribed by a Doctor and required for all normal, daily activities.
- Physical therapy rehabilitation to restore function and prevent disability following acute disease, injury or loss of body part with the expectation of significant improvement within two months. Covered therapy includes exercise, heat, cold, electricity, ultrasound and massage to improve circulation, strengthen muscles, encourage return of motion and train Members to perform the activities of daily living.
- Services and supplies required for the treatment of diabetes and diabetes self-management education programs.
- Outpatient Occupational, Speech and Hearing Therapy.
Occupational therapy means rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, injury or loss of body part with the expectation of significant improvement within two months. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.
Speech therapy means restoration of speech due to impairment following a recent physiological disturbance or injury, such as CVA, tracheostomy, swallowing disorders, laryngectomy and neuromuscular disease, with the expectation of significant improvement within two months.
- Reasonable costs associated with a search for a matched unrelated donor when the transplant is certified by us as Medically Necessary and is performed at a facility approved by and affiliated with the National Marrow Donor Program.

■ Is There a Limit On My Expenses?

The breakpoint maximums are shown in the Summary of Medical Benefits.

Calendar Year Breakpoint

If in any one calendar year a Member's covered expenses reach the individual breakpoint, all other covered expenses for that Member during the rest of that calendar year will be payable at 100%. No more than the individual breakpoint per Member will be applied to the family breakpoint.

Covered expenses for outpatient care of mental health conditions and chemical dependency treatment will *not* be payable at 100%, even if a Member has reached the breakpoint.

Expenses Excluded from the Breakpoint

Expenses that are not applied toward the breakpoint include expenses:

- for services and supplies not covered under this Plan.
- used to satisfy any deductible or copay amounts.
- for outpatient care of mental health conditions and chemical dependency.
- that are payable at 100%.

PRESCRIPTION DRUG BENEFITS

The prescription drug benefits are provided through two programs. The PCS Drug Program uses a nationwide network of PCS pharmacies. The Mail Order Drug Program lets Members order larger quantities of maintenance drugs through the mail to lower their out-of-pocket costs.

Covered drugs require the written prescription of a Doctor and approval by the FDA. Drugs must be purchased from a licensed pharmacist or Doctor. Benefits are payable only for drugs required for the treatment of Illness, when received as an outpatient and while covered for these benefits.

New FDA approved drugs are evaluated by the Pharmacy and Therapeutics Committee of our pharmacy benefit management company. Oversight and final approval are given by the One Health Plan medical directors.

Some drugs may have dispensing limits which are primarily based on FDA recommendations.

The PCS Drug Program

The PCS Drug Program covers charges for prescription drugs, allergy serums and insulin.

The PCS Drug Program covers a 34-day supply or 100-unit doses, whichever is greater, received in any one purchase.

When a Member presents their ID card at a PCS network pharmacy, the pharmacist will collect the appropriate copay and the Member won't have to file a claim.

If the Member doesn't show their ID card when filling a prescription, the Member will pay the full price of the prescription and must file a claim to be reimbursed. The reimbursement will be the negotiated pharmacy discount price less the copay.

When drugs are purchased at a pharmacy that is not a PCS pharmacy the Member must pay the full price of the prescription and file a claim to be reimbursed. If the pharmacy charges more for a prescription drug than a PCS pharmacy would charge, the Member will have to pay the difference.

Mail Order Drug Program

The Mail Order Drug Program covers costs for home delivery and expenses for prescription maintenance drugs required for treatment of illness. Prescription maintenance drugs are drugs prescribed by the Doctor on an ongoing basis. This includes expenses for insulin.

With this program, a Member may buy through the mail up to 90-day supplies of insulin and covered maintenance prescription drugs. Ask the Employer for a mail order drug brochure.

Ask the Doctor to prescribe needed medications for a 90-day supply, plus refills. If a Member is presently taking medications, the Member should ask the Doctor for a new prescription.

If Medication is Needed Immediately

If medication is needed immediately, the Member should ask the Doctor for two prescriptions. The first should be for a 14-day supply that the Member can have filled at a local PCS pharmacy. The second prescription should be mailed to the Mail Order Drug Program with the copay.

VISION BENEFITS

The Summary of Vision Benefits located in the front of the booklet shows the payment percentage applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Eye Exams

The Plan covers eye exams.

Eyeglass Lenses and Frames or Contact Lenses

The Plan covers eyeglass lenses and frames or contact lenses. Maximum amounts payable includes the cost of tinting, photograying and hardening of lenses.

LIFE INSURANCE BENEFITS

■ Standard Life Insurance

If you die from any cause while covered under the life insurance Plan, your amount of standard life insurance will be paid to your beneficiary. The amount will be based on the schedule shown in the front of this booklet.

■ How Do I Name a Beneficiary?

A beneficiary is the person who will receive payment of the life insurance amount if you die. You should name a beneficiary when you first apply for insurance. Unless legally restricted, you can change the beneficiary at any time by giving Great-West written notice. The beneficiary's consent is not required unless the designation of the beneficiary is irrevocable.

Naming or changing a beneficiary must be in writing, signed by you and filed with Great-West at its Executive Offices.

If a named beneficiary dies before you, the amount of the life insurance that beneficiary would have received will be paid to any remaining named beneficiaries who survive you, unless you have specified otherwise on your application or state law does not allow this.

When there are two or more named beneficiaries the life insurance will be divided in equal shares, unless you have specified otherwise.

Subject to state law, if no named beneficiary survives you or if you have not named a beneficiary, the amount of insurance will be paid to your surviving spouse; if none, then to your surviving child or children; if none, then to your surviving parent or parents; if none, then to your surviving brothers or sisters; if none, then to your estate.

■ **How Will Benefits Be Paid?**

Proof of death must be sent to Great-West. Great-West will pay the amount of insurance (the death benefit) to the beneficiary.

- The life insurance will be paid to the beneficiary. Prior to your death, you may elect to have your life insurance paid to your beneficiary in any manner to which Great-West agrees.
- If you do not elect an optional payment method prior to your death, then after your death the beneficiary may elect to have the life insurance paid to him or her in any manner to which Great-West agrees.

Payments will not be made more than once a year unless each payment is at least \$25.00.

■ **What If I Become Disabled?**

After you have been Totally Disabled for 9 consecutive months, insurance for yourself may be continued without further premium payment. To qualify for this benefit:

- You must become Totally Disabled while insured under this life insurance Plan;
- Your Total Disability must continue without interruption for at least 9 months;
- You must be under age 60 when you become Totally Disabled;
- You must send proof of your Total Disability to Great-West within 12 months of the start of the disability; and
- If you have converted to an individual policy under this Plan, you must surrender it. See “Conversion of Life Insurance Benefits” in the section entitled “When Coverage Begins & Ends.” All premiums paid for the individual policy after you have been Totally Disabled for 9 months will be returned. If you die during this 9 month period, the amount of insurance will be paid under either this life insurance Plan or the individual policy but *not* under both.

If you qualify for this disability waiver of premium benefit, you must send proof of the continuance of your Total Disability to Great-West when requested.

The amount of life insurance continued will be the amount in effect under this Plan on the date you became disabled. However, the amount of insurance may reduce or terminate due to age or retirement according to the provisions of the Plan that were in effect on the date you became Totally Disabled.

This life insurance Plan does not have to be in force at the time of death for life insurance to be paid.

Your disability waiver of premium benefit will terminate:

- On the date you recover from your Total Disability; or
- If you do not send Great-West proof of the continuance of your Total Disability when requested.

■ **Is the Amount of My Insurance Reduced As I Grow Older?**

Your amount of standard life insurance will be reduced according to the schedule shown in the front of this booklet.

■ **Life Insurance Benefits If Terminally Ill**

Any Accelerated Benefit that you receive may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

If you are terminally ill, you may apply to receive a portion of your life insurance as an Accelerated Benefit. In order to do this, you must be covered under this Plan and you must give Great-West satisfactory proof of having a Qualifying Medical Condition.

Qualifying Medical Condition means you are terminally ill, with a life expectancy of 12 months or less. In considering a request for an Accelerated Benefit, Great-West at its expense, may require that you be examined by a Doctor of its choice.

To apply for an Accelerated Benefit you must:

- contact your Employer for the appropriate application form; and
- send your application to Great-West along with a statement from your Doctor certifying the Qualifying Medical Condition.

For purposes of this benefit, the Doctor cannot be:

- yourself; or
- a person who is part of your immediate family (your parent, spouse, sibling or child); or
- a person who lives with you.

The request for an Accelerated Benefit must be made by the terminally ill insured person. However, if he or she is legally incapacitated or a minor child, the request must be made by a person with legal authority to act on the insured person's behalf.

You may request an Accelerated Benefit of up to 50% of the amount of your life insurance to a maximum of \$100,000.00. The minimum Accelerated Benefit is \$1,000.00.

The amount of the Accelerated Benefit available to you will be based on the amount of life insurance coverage provided to you by Great-West under this Plan when you request the Accelerated Benefit.

For any life insurance scheduled to reduce within 36 months of the date of application for the Accelerated Benefit, the amount of the Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid in a lump sum and is available only one time while covered by Great-West. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, Great-West will not ask you for a refund of the Accelerated Benefit. However, your amount of life insurance will be reduced as described below.

After payment of the Accelerated Benefit, the amount of your life insurance coverage under this Plan will be reduced by the amount of the Accelerated Benefit. If the Accelerated Benefit amount is equal to or exceeds the amount of life insurance in force at the time of your death, no additional amounts of life insurance will be payable upon your death.

Anyone approved for an Accelerated Benefit may also be approved for disability waiver of premium. (See "What If I Become Disabled?") Anyone already on disability waiver of premium when approved for an Accelerated Benefit, will continue on premium waiver.

No Accelerated Benefit will be paid if:

- All or part of your insurance must be paid to your children or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
- You are married and live in a community property state, unless you provide us with a signed statement from your spouse consenting to payment of the Accelerated Benefit.
- You have made an assignment of all or part of your life insurance, unless you provide Great-West with a signed statement from your assignee consenting to payment of the Accelerated Benefit.
- You have filed for bankruptcy, unless you provide Great-West with written approval from the bankruptcy court for payment of the Accelerated Benefit.
- You have previously received an Accelerated Benefit while covered under this Plan.

■ Other Information About Life Insurance

Absolute Assignment

You can transfer all your rights of ownership in your life insurance. This is known as absolute assignment. Great-West is not responsible for the validity or effect of any assignment.

To assign your life insurance, notify your Employer, who will contact Great-West for an assignment form. Great-West will not recognize an assignment until the original assignment form has been noted at its Executive Offices.

Collateral Assignment

You can assign your insurance as collateral for a loan. The interests of such an assignee come before those of a revocable beneficiary. A collateral assignment is not a transfer of ownership.

Proof of Age

Before benefits are paid, Great-West may request proof of age. An adjustment may be made if:

- The Member's age was misstated; and
- A different premium rate would have been charged for the person's true age.

The difference between the premiums actually paid, and those that should have been paid, will be calculated. Any difference will be paid:

- By your Employer to Great-West, if the age was understated; and
- By Great-West to your Employer, if the age was overstated.

AD&D BENEFITS

Your AD&D benefits are payable if you are in an Accident while covered under this AD&D Plan and suffer a loss:

- Within 90 days of the Accident and
- As a result of the Accident.

The amount of AD&D benefits that you may receive is based on a Principal Sum. The amount of your Principal Sum is equal to the amount of your Standard Life Insurance. (See "Standard Life Insurance" in the Life Insurance section of this booklet.) Great-West will pay all or part of the Principal Sum according to the AD&D Benefit table shown in the front of this booklet.

Only one of the amounts, the largest, will be paid for all injuries that result from any one Accident.

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

If you die, the benefit will be paid to the beneficiary you name for life insurance. If you suffer any other loss, the benefit will be paid to you.

To claim AD&D benefits, written proof of loss must be sent to Great-West as soon as reasonably possible. In any case, the proof required must be given no later than 15 months from the date of loss unless the claimant was legally incapable of doing so.

Your amount of AD&D Principal Sum is subject to the same age-based reductions as your life insurance.

BENEFIT LIMITATIONS

Pre-Existing Conditions Limitation for Medical Benefits

This section will *not* apply to a child placed with you for adoption.

A pre-existing condition is an illness or any related condition for which a Member received services, supplies or medication during the 3 months before the enrollment date of the Member under this medical Plan.

A pre-existing condition is not:

- A pregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received 12 months after the enrollment date for the Member.

Up to \$1,000.00 of charges for services, supplies and medication:

- received for the pre-existing condition after the date the Member became covered under this medical Plan; and
- which would otherwise be excluded by this limitation;

will be considered covered expenses. The Plan will *not* pay benefits for expenses incurred during a period of Hospital confinement which began before the person's coverage took effect.

Portability of Coverage

A person will receive credit toward this Plan's Pre-Existing Condition Limitation periods for the time covered under another health plan, but only if the person was covered, under another health plan that meets the definition of "Creditable Coverage", within the 63-day period just before his or her enrollment date under this Plan. Any eligibility waiting period that the person must satisfy under this Plan will not be considered in determining the 63-day period.

If the person was covered:

- For a period of time under Creditable Coverage that is greater than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- For a period of time under Creditable Coverage that is less than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitation under this Plan to be reduced or waived.

If a Member resides in Colorado and:

- The Member's coverage under this medical Plan has been in force for at least six months; and
- The Member has a pre-existing condition that will not be covered under this Plan because he has not satisfied the periods referred to in this provision;

Then, subject to payment of the required premium, the Member may be eligible for coverage under the Colorado High Risk Health Insurance Act, under the CoverColorado program.

For further information regarding CoverColorado, please contact:

CoverColorado
425 So. Cherry Street, Suite 160
Glendale, Colorado 80246
303-863-1960 or 1-800-672-8447 Option #4

Medical Benefit Limitations

No amount will be payable for:

- Services that are not Medically Necessary.
- Custodial care of a Member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or intercurrent health care needs.
Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of:
 - walking, transferring or positioning in bed and range of motion exercises;
 - self-administered medications;
 - meal preparation and feeding, by utensil, tube or gastronomy;
 - oral hygiene, skin and nail care, toilet use, routine enemas;
 - nasal oxygen applications, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.
- Special nursing services if those same services could be provided by the regular nursing staff of any Hospital in which the Member is confined.
- Charges by a Doctor for any phone call or interview during which the Member is not examined.
- Confinement, treatment, services or materials for educational or training problems or learning disorders.
- Outpatient physical, occupational or speech therapy for non-acute injuries, diseases or conditions that are not reasonably expected to result in significant clinical improvement within two months. This includes developmental progress in skills such as sitting, walking, talking and learning that compare unfavorably to measured results from standardized tests of others of the same age.

- Services or supplies which are primarily for the Member's education, training or development of skills needed to cope with an injury or sickness, except as specifically provided in the Plan.
- Any expense or charge associated with exercise equipment.
- Travel or transportation expenses, except for ambulance services, even if to reach a network facility.
- Plastic or reconstructive surgery that is not done to repair congenital defects, trauma, or an organ or tissue damaged by cancer, as defined in the section "What's Covered". Surgery to improve psychological function alone is not covered.
- Gene manipulation therapy.
- The reversal of any sterilization procedure.
- Massage.
- Surgical procedures for the improvement of vision when vision can be corrected through the use of glasses or contact lenses.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Dental services other than treatment of Accidental Injury to natural teeth within six months after the Accident. Chewing injuries are not considered an Accidental Injury.
- Non-prescription drugs or medicines, or drugs or medicines that are not approved by the Food and Drug Administration.
- Treatment for the purpose of weight loss, unless the Member is morbidly obese.
- Programs related to smoking cessation.
- Osteotomy, orthognathic surgery, maxillofacial orthopedics or related treatment for deformities caused by anything other than cancer or trauma.
- Hearing aids or the fitting of hearing aids.
- Elective abortions.
- Drugs, medicines or insulin which are received as an outpatient.
- The cost or fitting of contraceptive devices, when prescribed for the purpose of birth control.
- Any family planning procedure that requires outside intervention, such as, but not limited to, artificial insemination, in-vitro fertilization, GIFT or ZIFT.
- Infertility treatment.

Prescription Drug Benefit Limitations

No amount will be payable for:

- Therapeutic devices and appliances, except as specifically provided under the Plan.
- Over-the-counter drugs and supplies.
- The administration of drugs or allergy serums.
- More than one purchase of a drug, allergy serum or insulin during the dosage period recommended by the prescribing Doctor.
- Allergy serums under the Mail Order Drug Program.
- Contraceptive drugs and contraceptive devices, when prescribed for the purpose of birth control.

Vision Benefit Limitations

No amount will be payable for:

- Safety glasses.
- Radial keratotomy.
- Medical or surgical treatment of the eye.
- Artificial eyes.

AD&D Benefit Limitations

No amount will be payable for any loss caused by or in connection with:

- Intentionally self-inflicted injury.
- War or any act relating to war.

- Any form of disease.
- Physical or mental infirmity.
- The medical or surgical treatment of a disease or infirmity.
- Suicide.
- Potomac poisoning.
- Bacterial infections.
- Commission of a felony.

General Benefit Limitations

No amount will be payable for:

- Experimental or Investigational treatment or procedures.
- Vision therapy or orthoptic treatment.
- Anti-obesity drugs and formulas.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by your or your spouse's immediate or extended family.
- Care received for an illness that is a result of war or engaging in a riot or insurrection.
- Except for AD&D, an accidental injury that occurs while working for pay or profit.
- A sickness for which the Member can receive benefits under any Workers' Compensation or similar law.
- Injuries received in an accident involving a motor vehicle if the Member is a resident of Michigan and the accident occurs in Michigan.

CLAIMS & LEGAL ACTION

■ How To File Claims

A claim for benefits and services that have been provided may be filed by a Member, beneficiary or Authorized Representative. An ***Authorized Representative*** means a person or health care provider authorized in writing by the Member to represent the Member's interests for claim submission, pretreatment requests and appeals.

The Member's health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will also be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

All claim forms include instructions on how to complete and submit a claim. Members can request a claim form from the Plan Administrator or go to www.onehealthplan.com to print a copy of a claim form. Complete and accurate claim information is necessary to avoid claim-processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

Health Benefits

- Medical and Vision Benefits

Members who present their ID card when using a network provider will not have to file a claim. The ID card contains all the information network providers need to directly bill Great-West for the balance.

For other services, Members must file a claim. Sign the complete form, attach the itemized bill and mail both to the address on the Member ID card.

An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

For expenses incurred outside the United States, the Member must pay the bill and file a claim.

- Prescription Drug Benefits

For drugs purchased at a pharmacy, the only time a claim will need to be filed for reimbursement is when prescription drugs are purchased at a pharmacy that is *not* a PCS pharmacy, or when the Member does not show the ID card. Ask the Employer for a Prescription Drug claim form.

With the first Mail Order drug order, the Member should complete the member profile form found in the Mail Service brochure. Ask the Employer for a copy of this brochure.

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by Great-West. If a claim decision cannot be made within the 30-day period, an extension of up to 15 days may be requested. Before the end of the initial 30-day period, Great-West will send the Member written or electronic notice of the reason(s) for the delay.

Request for Additional Information

If the time to process a health claim is extended because the Member has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Member until the date Great-West receives the Member's response. Great-West will make a claim decision within 15 days after receipt of the requested information. Members should submit the requested information within 45 days of receipt of the request. If the Member does not respond within the 45-day period, the claim may be denied.

Life Insurance Benefits

The beneficiary should contact the Employer for the claim form. Proof of death must be sent to Great-West. After the claim is processed, Great-West will pay the amount of insurance (the death benefit) to the beneficiary(ies).

AD&D Benefits

You or your beneficiary should contact the Employer for the claim form.

■ If A Claim Is Denied

If any insured benefits are denied the Member will be sent a written notice. This notice will state the reasons for the denial, the reference to the Plan provisions on which the denial is based and what is needed to complete the claim.

If any self-funded benefits are denied, in whole or in part, Great-West will send the Member a written or electronic notice within the established time periods described in the section How to File Claims. The Member or Authorized Representative may appeal the denial as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and the Member's right to bring civil action under ERISA section 502(a).

If the denial involves a health or disability claim, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

For insured benefits, the Member must be given notice of claim denial within 90 days after the claim is filed. If special circumstances require more than 90 days, another 90 days will be allowed. If an extension is needed, the Member will be notified before the end of the initial 90-day period.

Appeal of a Denied Claim for Insured Benefits

The Member can request a review of any denied claim or the status of a pending claim by contacting the Benefit Payment Review Department located at Great-West's Executive Office in Greenwood Village, Colorado.

The Benefit Payment Review staff may consult with Great-West's Law Department to assist them in the claims review process.

For insured benefits, Great-West has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

If a Member is not satisfied with the final disposition of the claims review process, the Member can initiate an appeal by giving written notice within 60 days after receipt of the written claim denial. This appeal must be filed before the Member may file a lawsuit.

The Member or anyone authorized to act on the Member's behalf may appeal the claim and ask to examine any pertinent documents. The Member should submit in writing the reasons why the claim should not have been denied, as well as any other information, questions or comments.

Appeals must be submitted in writing to Great-West.

The Member will be notified of the final decision within 60 days after receipt of a request for review. If special circumstances require an extension, a further 60 days will be allowed.

Appeal of a Denied Claim for Self-Funded Benefits

After receiving notice of a claim denial, in whole or in part, the Member, beneficiary, provider or Authorized Representative can appeal by submitting a written request to Great-West. The appeal will be reviewed by an individual *who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination*. An appeal includes the right to review and request copies of relevant documents, free of charge, and to submit issues and comments in writing.

An appeal of a health claim should be submitted within 180 days after receipt of a claim denial. If the first level appeal review results in an adverse determination, a request for a second level appeal review should be submitted within 60 days after receipt of the Level I appeal determination.

Health Claim

To appeal a health claim denial, a written appeal request must be submitted to Health Claim Appeal, P.O. Box 22222, Fort Scott, KS 66701. The appeal request should include the Member's and the Employee's name and identification number, the date of service, address and telephone number of the Member and the provider, and a description of the appeal.

Residents of Wisconsin

A grievance is any dissatisfaction with administration or claim practices or the provision of services by a Hospital or Physician. The Member or his or her representative must express the grievance in writing.

A Member has the right to appear in person before the internal grievance committee to present written or oral information and to question those people responsible for making the determination. The Member will be informed in writing at least 7 days in advance of the time and place of the grievance committee meeting.

Health Claim Appeals

Two levels of appeal for Health claims must be completed before a Member may bring civil action under ERISA for an adverse determination. (See Statement of ERISA Rights in the CLAIMS & LEGAL ACTION section of the booklet.)

- For appeal of a health claim that involves Medical Management, the first level of appeal is an internal review. The second level of appeal is an external review. The external review decision is binding on the Plan.
- For appeal of a health claim that does *not* involve Medical Management, both the first and second levels of appeal are subject to internal review. Voluntary appeals are available at the Member's request when new information is provided.

Each level of a health claim appeal will be processed within 30 days of the date the request for appeal is received by Great-West.

In the case of an adverse decision of a health appeal, the notice will specify the reason(s) for the denial, the Plan provision(s) on which the denial is based, the Member's right to review and request copies of all relevant documents, free of charge, and the Member's right to bring a civil action under ERISA section 502(a).

The notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.
- that the Member and the Member's Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and the state insurance regulatory agency.

■ What If a Member Has Other Health Coverage?

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee's spouse's employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;
- Any other group insurance or prepayment plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile no-fault insurance plan.

Which Plan Is Primary?

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
 - the plan of the parent whose birthday falls earlier in a year will be primary; but
 - if both parents have the same birthday, the plan that covered the parent longer will be primary.

However:

- If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
- If the parents are legally separated or divorced, benefits for the child will be determined in this order:
 - * first, the plan of the parent with custody of the child will pay its benefits;
 - * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
 - * finally, the plan of the parent not having custody of the child will pay its benefits.

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.

- A plan that covers a person as:
 - a laid-off or retired employee; or
 - a Dependent of such an employee; or
 - a continuee under a state or Federal law;

will determine its benefits after the benefits of any other plan covering that person as an employee.

If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
 - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and

- the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if there were no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% rather than partial payment of allowable expenses that are incurred by the same person within the same calendar year.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

■ **How Will Benefits Be Affected By Medicare?**

The following applies to you if you are an active Employee and you or your spouse becomes eligible for Medicare **due to age**. You and your Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then this medical Plan will be considered the Member's primary coverage, and Medicare will be considered the Member's secondary coverage. This means that benefits under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then Medicare will be considered primary, and this medical Plan will be considered secondary.

The following applies to you if you are an active Employee and you or your Dependents become eligible for Medicare **due to disability**. You and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then coverage under this medical Plan will be considered the primary coverage, and Medicare will be considered the secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, Medicare will be considered the primary coverage, and coverage under this Plan will be considered the secondary coverage.

If A Member Becomes Eligible for Medicare Due to End-Stage Renal Disease (ESRD)

Under Medicare law, a Member must complete a waiting period, typically three months, before becoming eligible for Medicare solely because of ESRD. During this waiting period, this Plan will pay benefits and Medicare will not pay any benefits.

After the waiting period, for the first 30 months of eligibility for Medicare Part A benefits solely due to ESRD, this Plan will pay its benefits first (primary payer) and Medicare will pay its benefits second (secondary payer). After that, if the Member is still eligible for Medicare due to ESRD, Medicare will be the primary payer and this Plan will be the secondary payer.

In certain circumstances, such as a kidney transplant, the 30-month time frame that this Plan will be the primary payer may be less as defined by the Medicare guidelines for determining primary payer.

If the Member becomes eligible for Medicare due to ESRD after Medicare became the primary payer under any other provision of Medicare law or this Plan, Medicare will be the primary payer and this Plan will be the secondary payer.

Treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan.

A Member is eligible for Medicare when:

- the Member is covered under Medicare; or
- the Member is not covered under Medicare due to:
 - the Member's refusal of Medicare coverage;
 - the Member's voluntary termination of Medicare coverage; or
 - the Member's failure to apply for Medicare coverage.

■ **How Will Benefits Be Affected If a Member is Eligible to Receive Treatment in a Uniformed Services Facility?**

A Member who is a uniformed services beneficiary is eligible to receive reimbursement under the Plan at the highest coinsurance level shown on the Summary of Benefits for the covered services provided by a uniformed services facility or provided indirectly by a federal government entity.

For benefits to be paid under this Plan, the Member is required to:

- disclose to the uniformed services provider, information about his or her coverage under the Plan and any pre-treatment requirements.
- make sure that the uniformed services provider calls Medical Management for pre-authorization and that the medical treatment has been approved by Medical Management.
- submit a claim for reimbursement of a prescription drug dispensed by the uniformed services facility. Some drugs may require prior approval.

■ **Provision for Subrogation and Right of Recovery**

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a Workers' Compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, Great-West may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to Great-West any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with Great-West in asserting its subrogation and recovery rights. The Covered Person will, upon request from Great-West, provide all information and sign and return all documents necessary to exercise Great-West's rights under this provision.

Great-West will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by Great-West for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. Great-West will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse Great-West for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to Great-West for the amount of the benefits paid under this Plan; and
- Great-West may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

Great-West's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or
- on behalf of any incapacitated person.

■ Other Information A Member Needs to Know

Incontestability of Life Insurance and AD&D Benefits

After this Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years a Member is covered under this Plan, only a written statement signed by the Member can be used to contest the validity of the Member's coverage. After the Member's coverage has been in force for 2 years during the Member's lifetime, no statement by the Member can be used to contest the validity of the Member's coverage.

Proof of Claim

Send written claim to Great-West as soon as reasonably possible. A Member must submit a written claim no later than 15 months from the date the claim is incurred, unless legally incapable of doing so.

Complaint Process

For concerns or complaints, call Member Services at (800) 663-8081. Whether the issue involves health care or the administration of coverage, Great-West's representatives will do what they can to make sure it's addressed. No retaliatory action will be taken by Great-West against the Member because of a complaint. Great-West's goal is for the Member to be completely satisfied with the measures taken to resolve the issue. However, if a Member is not satisfied, Great-West's representatives can help the Member begin the formal complaint process. If the issue is not resolved to the Member's satisfaction, the Member may appeal.

If the Member's complaint is in regard to:

- A preauthorization determination, see Medical Management (MM) Program, within the MEDICAL BENEFITS section.
- Timely claim payment or a denial of a claim, see How to File Claims, within the CLAIMS & LEGAL ACTION section.

For all other complaints, including those related to availability, delivery or quality of a health care service, contact Member Services for an explanation of the complaint process.

Payment of Claims

Benefits payable under the Plan will be paid as described in the booklet section CLAIMS & LEGAL ACTION.

For life insurance, the death benefit will be paid to the beneficiary(ies).

For other benefits, the benefits will be paid to the Member, if living. If not, benefits will be paid to the Member's estate. If any benefit is payable to the Member's estate or to a person who cannot give a valid release, then Great-West can pay up to \$1,000.00 to any relative it considers to be entitled to such payment. The Member may request in writing that payments under the Plan be made directly to the person providing the services.

Legal Actions

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Physical Examinations and Autopsy

Great-West, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary. Great-West may also have an autopsy done where it is not against the law.

Other General Information

Arkansas law requires that the following information be provided to all Arkansas residents:

REGIONAL SALES OFFICE

Great-West Life & Annuity Insurance Company

Group Sales

Suite 1000

One Lincoln Center

5400 LBJ Freeway

Dallas, Texas 75240

Telephone: (972) 458-0990

LOCAL INSURANCE DEPARTMENT

Arkansas Insurance Department

Consumer Service Division

1200 West 3rd Street

Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2640

Benefit Payments to a Representative of a Minor

In the case of a minor child who otherwise qualifies as a Dependent under the Plan, if the child designates a representative, then the Plan must pay benefits on behalf of that child to his or her representative, even if that person is not covered under the Plan. The person must:

- Submit written notice that he or she is the representative of the child on whose behalf the claim is made; and
- Provide evidence that the person qualifies to be paid the benefits.

Relationship Between Great-West and Network Providers

Providers under contract with Great-West are independent contractors. Network providers are neither agents nor employees of Great-West, nor is Great-West, or any employee of Great-West, an agent or employee of Network providers. Great-West will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

■ ERISA General Information

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

This summary plan description describes the benefits available to Employees of UAW GM LEGAL SERVICES PLAN, the Plan Sponsor/Employer.

The address of the Plan Sponsor/Employer is 7430 SECOND AVENUE ALBERT KAHN BUILDING, DETROIT, MI 48202. The telephone number is (313) 872-1700 EXT. 0550.

The Employer Identification Number (EIN) is 38-6452301. The Plan Number assigned by the Plan Sponsor is 501.

The Agent for Service of Legal Process is the Plan Trustee or the Plan Administrator, ELAINE ELZELMAN, PLAN ADMINISTRATOR.

The Plan provides Life and AD&D Insurance, Medical, Prescription Drug and Vision Benefits.

See the section, "About This Plan" for more information about the Insured and Self-Funded benefits.

Great-West Life & Annuity Insurance Company provides Contract Administration.

The eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The fiscal records of the Plan are maintained on the basis of Plan years ending JUNE 30.

Claims

Procedures to be followed in presenting claims for benefits and what to do when claims are denied in whole or in part are described in the "How To File Claims" section of this booklet.

■ **Statement of ERISA Rights**

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits.

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

However, Employers with fewer than 100 Employees at the beginning of the Plan Year are not required to:

- **allow examination of the Annual Report or Plan Description; or**
- **furnish copies of the Plan Description, Annual Report, or any Terminal Report.**

- Continue Group Health Plan Coverage.

You may be eligible to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. You may review this summary plan description and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months if you are a late enrollee) after your enrollment date in your coverage.

- Prudent Actions by Plan Fiduciaries.

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

- **Enforce Your Rights.**

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

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

- **Assistance With Your Questions.**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

The Following May Be Obtained Upon Written Request to the Plan Administrator:

A copy of any collective bargaining agreement pursuant to which the Plan is maintained.

GLOSSARY

The following defined terms have a special meaning with respect to the benefits outlined in this booklet. On each page where they appear throughout this booklet, they are capitalized.

Accident/Accidental Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

Actively at Work

Employment on an active and full-time basis at the Employer’s usual place of business.

Creditable Coverage

Coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

Dentist

A person licensed to practice dentistry.

Dependent

- Your legal spouse;
- Any unmarried child under the age of 19; or

- An unmarried child under the age of 25 if he or she is a full-time student. Before paying a claim, the Plan may require proof that this child is a full-time student.

For medical, prescription drug and vision benefits, the age limits do not apply to a child who cannot hold a self-supporting job due to a permanent physical handicap or mental retardation if:

- the child becomes and remains handicapped while covered under the Plan; or
- the child was covered under the Employer's prior plan that this Plan replaces.

At reasonable intervals, but not more often than annually, the Plan may require a Doctor's certificate as proof of the child's handicap.

"Physical handicap/mental retardation" means permanent physical or mental impairment that is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

"Permanent physical or mental impairment" means:

- a physiological condition, skeletal or motor deficit; or
- mental retardation or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

The term "child" means:

- Your children. This includes any step-child or adopted child.

For a child to be considered a Dependent he or she must be chiefly dependent upon you for financial support. This requirement is waived if the child is eligible for coverage because of a Qualified Medical Child Support Order, or, if state law so requires, a non-qualifying court order or an administrative order of any state agency.

Your Dependents must live in the United States to be eligible for coverage.

A person who is covered under this Plan as an Employee may not be covered as a Dependent.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if:

- He or she performs a service within the scope of his or her license and for which this Plan provides coverage; and
- State law requires such practitioner to be covered.

Employee

A person who is in the Service of the Employer and is a resident of the United States.

Employer

- UAW GM LEGAL SERVICES PLAN; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

Experimental or Investigational

A drug, device, medical treatment or procedure which:

- Cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
- Is the subject of a current investigational new drug or new device application on file with the FDA; or
- Is being provided pursuant to:
 - A Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
 - A written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives;

- Is being delivered, or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services (HHS);
- In the predominant opinion among experts:
 - As expressed in the published, authoritative literature, is substantially confined to use in research settings;
 - Is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or
 - Is experimental, investigational, unproven or is not a generally acceptable medical practice; or
- Is not a covered service under Medicare because it is considered investigational or experimental as determined by the Health Care Financing Administration (HCFA) of HHS;
- Is provided concomitantly to a treatment, procedure, device or drug which is experimental, investigational, unproven Treatment; or
- Has not been performed at least ten (10) times and reported on in United States peer review medical literature.

Great-West's Medical Director may, in his/her sole discretion, determine that a drug, device, medical treatment or procedure which is deemed experimental or investigational under the above criteria, should nonetheless not be deemed experimental or investigational.

Hospital

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, unless required by state law, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Illness

An Accidental Injury, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

Loss of Residence

Being outside the United States for more than 60 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 60 continuous days.

Medically Necessary

Any service or supply for diagnosis or treatment that is:

- Prescribed by a Doctor to be necessary and appropriate; and
- Non-experimental or non-investigational; and
- Not in conflict with accepted medical or surgical practices prevailing in the geographic area where, and at the time when, the service or supply is ordered.

To ensure that all Members receive an objective consideration, ONE bases its reviews on a variety of criteria. These criteria include relying on accepted medical standards, calling on ONE's experience in the review of medical care, and looking to ONE's team of providers for guidance.

Medical necessity does not include any service or supply that is for the psychological support, education or vocational training of the Member. Medical necessity does not include implant of any artificial organ for any reason whatsoever.

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare+Choice plans.

Member

An Employee and any covered Dependent.

Plan

UAW GM LEGAL SERVICES PLAN (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The benefits described in this booklet constitute benefits available under the plan and are referred to collectively in this booklet as “the Plan.”

Proof of Good Health

Written evidence that the person meets Great-West’s general underwriting standards. Such evidence includes but is not limited to medical evidence.

Service

Work with the Employer on an active, full-time and full pay basis for at least 30.00 hours per week.

Totally Disabled and Total Disability

Life Insurance

Being under the care of a Doctor and prevented by Illness from working for pay or profit in any job for which you are or may become suited by reason of education, training or experience.

Employee Medical Benefits

Being under the care of a Doctor and prevented by Illness from performing your regular work.

Dependent Benefits

Being under the care of a Doctor and prevented by Illness from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

You and Your

An Employee.