MEMO: ENROLLED Employees of Michigan Gutters

Blue Care Network plan

Companion Dental plan

The Hartford Life Insurance plan

Andi Dolan, Traverse Benefits 231.640.0022, will be reaching out to you in the coming days to review your benefits with you.

Please be prepared to ask questions and review these above-named benefits that you are offered through Michigan Gutters.

Please be prepared to share your email address with Traverse Benefits as you will be receiving your summary plan descriptions through this method.

Steve and Carrie Ball

Michigan Gutters Inc.

Employees' Acknowledgement of MGI's Comprehensive Health and Welfare Benefits Plan and Summary Plan Description Information

I acknowledge that I have been provided a Comprehensive Health and Welfare Benefits Plan and Summary Plan Description.

I acknowledge that I understand the Company policy.

Employee's Printed Name:_____

Employee's Signature_____ Date: _____

Comprehensive Health and Welfare Benefits Plan and Summary Plan Description Information

for

Michigan Gutters

Effective June 1, 2019

TABLE OF CONTENTS

I. Introduction to Michigan Gutters, Inc Group's Comprehensive Health and Welfare Benefit Plan

A. Plan Provided

This Summary Plan Description is intended to serve all business entities associated with "the company," Michigan Gutters, Inc.

The company maintains a Comprehensive Health and Welfare Benefit Plan ("Plan") for the exclusive benefit of eligible employees as well as their spouses and/or dependents. The Plan provides benefits through a variety of component parts, which include:

Blue Care Network of Michigan Group Health Plan
Group ID 00413503 0001-0001;0002

Companion Life, Group Dental

Group ID 336-14-06401-000

The Hartford, Group Life

Group ID 885407

This document is intended to function as the Summary Plan Descriptions for the Michigan Gutters, Inc. Comprehensive Health and Welfare Benefit Plan. Eligibility for each component part of the plan may vary based upon an employee's employment classification, and not every employee may be eligible to participate in every benefit identified in this document.

Some of the component benefit programs require you to make an annual election to enroll for coverage. Others require only an initial enrollment. You will be notified of these requirements when you enroll in the individual component benefit programs. Additionally, for those plans requiring an annual enrollment, an announcement will be made as to when open enrollment will take place.

B. Detailed Plan Information

In addition to this document, some or all of the above noted component parts of the Plan may be summarized in more detail in a variety of different documents that are provided separately to participants, such as certificate of insurance booklets, plan documents, benefit-specific summary plan descriptions, or other governing documents (hereinafter the "Component Plan Documents). Such summaries will typically be prepared and/or issued by Michigan Gutters, Inc., a third-party administrator, or an insurance provider. This Summary Plan Description information is intended to work in conjunction with those documents, and it is recommended that participants attach this document to the certificates of coverage and/or other plan documents they may have received for both ease of reference, and to help ensure that they have the most comprehensive benefits information possible. If you have any questions about how to obtain another copy of the Plan document(s), please contact the Plan Administrator's Designee listed in Section III.A.5. of this document.

C. Plan Document and Summary Plan Description Requirements

Some or all of the component parts of this plan may be covered by ERISA (which is a Federal law regulating health and welfare benefits plans). To the extent any component part of this Plan is not covered by ERISA, this Plan will in no way change the non-ERISA nature of the component part of the Plan. For those component parts of the Plan that are covered by ERISA, this document is not intended to give you any substantive rights to benefits that are not already provided in the Plan document(s). This document, along with the Component Plan Documents, constitute both a written plan document and Summary Plan Description, as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The above-referenced documents supersede and replace any prior Summary Plan Descriptions.

D. Assistance in Non-English Language

This document, along with the Component Plan Documents, contain a summary in English of your plan rights and benefits under Michigan Gutters, Inc Comprehensive Health and Welfare Benefit Plan. If you have difficulty understanding any part of these documents, contact the Plan Administrator's Designee identified in Section III of this document.

II. Benefits Offered Within this Plan

Benefit Plan	Eligibility	When Participation Begins
Health Plan / Health Savings Account	Employees hired as Full-Time employees, scheduled to work 30 hours per week. Spouse Dependents to age 26	**First of the month following 30 days after date of hire**
Dental Coverage	Employees hired as Full-Time employees, scheduled to work more than 30 hours per week.	**First of the month following 30 days after date of hire**
Base Life and Accidental Death & Dismemberment Voluntary Life and Accidental Death & Dismemberment	Employees hired as Full-Time employees, scheduled to work more than 30 hours per week. Spouse	**First of the month following 30 days after date of hire**

Disclaimer: *The above benefits are provided pursuant to the provisions of an insurance certificate, HMO contract or governing plan document adopted by Michigan Gutters, Inc referenced in Section I, B. above). If any of the terms of this document conflict with the terms of such insurance certificate, HMO contract or governing plan document, then the terms of the insurance certificate contract or governing plan document will control.*

III. Additional Summary Plan Description & Component Plan Information

A. General Plan Information

1. **Plan Sponsor and Address**
   Michigan Gutters, Inc.
   1616 W South Airport Rd,
   Traverse City, 49686
   (231) 933-1244

2. **Plan Name and Identification Number**
   Michigan Gutters, Inc. Comprehensive Health and Welfare Benefits Plan
   Employer Federal Tax Identification
   26-3849483
   Plan Number: 501
   Effective Date: June 1, 2019

3. **Type of Plan**
   Comprehensive Health and Welfare Benefits Plan providing a variety of benefits (including health insurance) as set forth in this document.

4. **Other Contacts for Benefit/Claim Information**

   Health Plan
   Blue Care Network of Michigan
   600 E. Lafayette Blvd.,
   M.C. CS3A
   Detroit, MI 48226-2998
   FAX: (877) 348-2210

   Dental Plan
   Companion Life Insurance
   7909 Parklane Road
   Columbia, SC 29223

   Base & Voluntary Life and Accidental Death & Dismemberment
   The Hartford Financial Group
   8711 University East Drive
   Charlotte, NC 28213

   Insurance Agency / TPA
   Traverse Benefits
   P.O. Box 4023
   Traverse City, MI 49685
   (231) 640-0022
   andi@traversebenefit.com

5. Plan Administrator / Plan Fiduciary

Michigan Gutters, Inc. is the Plan Administrator. Michigan Gutters, Inc is also the Plan Fiduciary and the agent for the service of legal process on the Plan. Michigan Gutters, Inc has designated the following individual to act on behalf of the Plan Administrator:

Steve Ball
Carrie Ball
Traverse Benefits

The Plan Administrator maintains the Plan's records, manages the operation of the Plan and interprets the Plan's provisions. In general, it is the duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of the persons entitled to participate in the Plan without discrimination among them. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the plan.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Some component benefits under the Plan may be fully-insured, provided by contract with a HMO or insurance company, or administered by a third-party administrator. In such cases, the insurance company, HMO, or third-party administrator will generally be responsible for determining both:

i. Eligibility for coverage (if any) and the amount of benefits payable (if any) under the Plan; and

ii. The claims procedures to be followed and claims forms to be used by employees and their dependents under the plan. (Detailed claims procedures are contained in the insurance certificates, plan documents, or summary plan descriptions for each component part of the plan).

Employee eligibility for one or more component parts of the plan (in particular, the group health plan) may be determined by the Plan Administrator according to a special measurement method (called the "look-back" method) to determine whether employees have sufficient hours of service to obtain full-time status for purposes of group health coverage, based on rules adopted by the IRS to comply with the Patient Protection and Affordable Care Act ("ACA"). Under the look-back method, an employee's hours of service will be calculated over a "measurement period" to determine whether or not the employee will be considered to be a full-time employee under the ACA during a subsequent "stability period" that is the same length as the measurement period. Details regarding the measurement and stability periods, and the rules for counting hours of service are available upon request to the Plan Administrator. Determination of eligibility and full-time status for each component part of the plan will be made at the sole and absolute discretion of the Plan Administrator, and may take into account the definition of "full-time" employee contained in the ACA.

If you have any general questions regarding the Plan, your eligibility, or the amount of benefits payable under the Plan, contact the appropriate insurance company, HMO or third-party administrator (as identified in the previous section). Inquiries may also be directed to the Plan Administrator's Designee.

6. **Plan Year: June 1 – May 31**

7. **Amendment to, Loss of, or Termination of Benefits**

Michigan Gutters, Inc. reserves the right to amend or terminate the Plan, any component parts of the Plan, and any employee contribution amounts at any time without the consent of any participant or beneficiary. Likewise, the costs of participating in the component parts of the Plan may be increased at our discretion, or the discretion of any insurance companies or third-party administrators with whom we have contracted.

Your coverage under this Plan will terminate if:

A. You no longer meet the eligibility requirements of the Plan
B. You cease to make required employee contributions (if any), or
C. The Plan terminates.

More detailed information regarding the reasons you or your dependents could lose your eligibility for any of the component parts of the Plan can be found in the certificates of coverage, plan documents, or summary plan descriptions for each component part of the Plan. The Plan (and any subsequent amendments) may be amended or terminated by a written instrument signed by the individual authorized above to act on behalf of the Plan Administrator or other designee.

8. **No Contract of Employment**

The Plan is not intended to be, nor shall be construed as, a contract of employment or other arrangement between the employee and Michigan Gutters, Inc., and shall not have any effect on the right of either the employer or the employee to terminate the employment relationship at any time, with or without notice.

9. Termination of Benefits

Your participation in the Plan (and that of your eligible family members) will terminate immediately upon the occurrence of a "qualifying event" (such as termination or reduction of work hours). However, the ability of you and/or any of your eligible dependents to continue participating in any of the component parts of the Plan after the occurrence of a "qualifying event" will be determined by the individual certificates of coverage, master contracts, plan documents, benefit summaries or other governing documents for each component part of the Plan. Please see the certificates of coverage, master contracts, plan documents, benefit summaries or other governing documents for each component part of the Plan to determine which termination date will apply.

Additional causes for the termination of coverage in this Plan or any component parts of the Plan include, but may not be limited to, the failure to pay your share of an applicable premium, the reduction of your work hours below any required hourly threshold, and the submission by you of any false claims. For additional details regarding the timelines and circumstances of benefits termination please refer to the certificates of coverage, master contracts, plan documents, benefit summaries or other governing documents for each component benefit program.

10. Restrictions on Receiving Benefits

The benefits available to certain employees of Michigan Gutters, Inc. who are officers, directors, or highly compensated may be restricted in certain circumstances. The Internal Revenue Code sets limitations on the amount and/or percentages of some benefits that may be received by certain classes of employee. If Michigan Gutters, Inc. believes that the limits may be exceeded, Michigan Gutters, Inc. may arbitrarily limit the amount of employee contribution such participants may allocate to nontaxable benefits, so that the limit will not be exceeded.

11. Funding Medium

Contributions and funding for the component parts of the Plan may be derived from three primary sources:

1) contributions from the general assets of Michigan Gutters, Inc;
2) before-tax contributions from employees; and
3) after-tax contributions from employees.

These contributions are paid to the plan sponsors, insurers, or third-party administrators for each component part of the Plan (as listed in the General Plan Information section above) according to the certificates of insurance, master contracts, plan documents, or other governing documents for each plan.

The Employer makes contributions under the Plan on behalf of the employees who participate in the Plan. Employer applies its contributions under the Plan to purchase insurance coverage. Employees may be required to contribute to the cost of coverage. If employees are required to contribute to the cost of coverage, Employer will notify employees of the required premiums. If Employer maintains a Section 125 plan, required premiums may be paid on a pre-tax basis.

Employer/ Employee contributions the Michigan Gutters, Inc. Benefits plans are as follows:

Group Medical: Michigan Gutters, Inc. will pay 50% of employee's premiums (single, double and family) up to $500.

Group Dental: Michigan Gutters, Inc. will pay 50% of the employee's (single only) dental premiums

Group Life Insurance: Michigan Gutters, Inc. will pay 100% of the employee's 25,000 Life insurance premiums. Should the employee wish to voluntarily purchase "more" life for him/her self, they will be responsible for paying for additional coverages for themselves and their dependents.

These above Employer/Employee contributions are subject to change on a plan year basis (June 1 – May 31).

12. Loss or Recovery of Benefits

The Plan may recover overpaid benefits and erroneously paid benefits through its right to subrogation and reimbursement. These Plan rights are described in further detail in the certificates of insurance, master contracts, plan documents, or other governing documents for each component part of the Plan.

13. Filing a Claim and Claim Denial

Fully-Insured Plans:

For purposes of determining the amount of, and entitlement to, benefits under a fully-insured component part of the Plan (as identified in the General Plan Information section above), the respective insurer or HMO is a fiduciary under the Plan, and has the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract.

To obtain benefits under a fully-insured component part of the Plan, you must follow the claims procedures under the applicable insurance or HMO contract, which may require you to complete, sign and submit a written claim on a specified form. Contact the Plan Administrator's Designee for any such forms.

The insurance company or HMO will decide your claim in accordance with its reasonable claims' procedures, as required by ERISA. The insurance company or HMO has the right to secure independent medical advice, and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company or HMO denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or HMO for a review of the denied claim. The insurance company or HMO will decide your appeal in accordance with its reasonable claims' procedures, as required by ERISA. If you fail to appeal on in a timely fashion, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing legal action).

For more detailed information regarding claims processing, denials, and appeals, please see the certificates of insurance, plan documents, or other governing documents for each component part of the Plan.

B. Government Required Notices

1. ERISA Rights

Your 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

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan or its component parts, including insurance contracts, plan documents, and collective bargaining agreements (if applicable), and copies of the latest annual Form 5500 report (if any). The Administrator may make a reasonable charge for the copies.

Receive a summary annual report in connection with any Form 5500 report that may be filed in connection with this Plan (if any).

Continue Group Health Plan Coverage

Michigan Gutters, Inc. is under the required threshold to offer continuation of health coverage. COBRA is not applicable at this time.

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 health and welfare benefit plans that may be covered by ERISA. The people who operate your plans, who are "fiduciaries" of those plans, 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 (if applicable), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining Plan benefits or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan or one of its component parts is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain

copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of insurance contracts, plan documents, or the latest annual Form 5500 report (if any) and do not receive them within 30 days, you may file suit in a 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you, you may file suit in a state or Federal court. In addition, if you disagree with a decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse a 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 the Plan or its component parts, you should contact the Plan Administrator's Designee or our third-party 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 U.S. Department of Labor's Employee Benefits Security Administration, or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration, or visiting their website: **www.dol.gov/ebsa.**

2. COBRA Rights

Introduction

This notice generally explains COBRA continuation coverage.

NOTE: Michigan Gutters, Inc. is not, at this time, at the threshold to comply with COBRA.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa** (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator's Designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator's Designee.

3. **HIPAA Notice**

Your HIPAA Rights:

The Health Insurance Portability and Accountability Act (HIPAA) provides for a special enrollment right if you, or a spouse and dependent, lose coverage elsewhere or obtain a new dependent through marriage, birth or adoption. The requirements for the special enrollment right are detailed below.

Loss of Coverage:

If you decline enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, and that coverage terminates due to certain qualifying reasons, you may be entitled to a special enrollment period in one or more component parts of the Plan. The qualifying reasons leading to a special enrollment right for loss of coverage are:

> Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment or reduction in hours; or Because employer contributions for the other coverage cease.

Should one of the above noted events occur, you must **notify the Plan within 30 days** to take advantage of this special enrollment right. You must inform the Plan Administrator in writing at the time you decline coverage that you are declining coverage because of other health insurance coverage in order to be eligible for this special enrollment period.

Marriage, Birth or Adoption:

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and your newly acquired dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

Loss of Medicaid or State Child Health Plan (CHIP) Coverage:

If you and/or your dependents were covered under a Medicaid plan or State Child Health Plan (CHIP) and that coverage is being terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents on the health plan, provided you request enrollment within 60 days after the date that termination of such coverage occurred, and that you meet certain other important conditions described in the insurance certificates, plan documents, or other governing documents of each component part of the Plan. Coverage under this plan will be effective on the date the other coverage ended.

Eligibility for Premium Subsidy Assistance under Medicaid or State Child Health Plan (CHIP):

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or State Child Health Plan (CHIP) for a premium subsidy assistance, you may be able to enroll yourself and your dependents on the health plan, provided you request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents, and that you meet certain other important conditions as described in the insurance certificates, plan documents, or other governing documents of each component part of the Plan.

4. Qualified Medical Child Support Orders

The Plan will comply with Qualified Medical Child Support Orders (QMCSO) as required by ERISA. A QMCSO is a court order typically issued as part of a divorce or a state child support order that requires health plan coverage for the child of a plan participant.

The procedures to comply with a QMCSO are available to employees. Contact the Plan Administrator's Designee for the QMCSO procedures.

5. Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires that all group health plans that provide coverage for mastectomies also provide coverage for breast reconstructive surgery in connection with that mastectomy.

All participants and beneficiaries who receive benefits under the group health plan with respect to a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

Reconstruction of the breast on which the mastectomy was performed.

Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call the Plan Administrator's Designee.

6. Rights under Newborns and Mothers Health Protection Act

Under the Newborns and Mothers Health Protection Act (NMHPA), group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours, as applicable).

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Plan Administrator's Designee.

C. Organizational Resolution

Amendment and Restatement of Comprehensive Health and Welfare Benefit Plans

WHEREAS, Michigan Gutters, Inc. maintains certain employee health and welfare benefits plans providing the following benefits:

Blue Care Network of Michigan, Group Health Plan
Companion Life, Group Dental
The Hartford, Group Life

WHEREAS, Michigan Gutters, Inc. wishes to treat the ERISA covered components of such benefit programs (as may be in effect as of the date of this Resolution, and as any one of them may be amended from time to time), and any additional ERISA covered benefit program that may be added by duly authorized action of the corporation or its representatives, as one Health and Welfare Benefit Plan for purposes of required governmental reports and required disclosure to participants and certain beneficiaries, and for COBRA election purposes (to the extent any component part of this Plan is not covered by ERISA, this Plan will in no way change the non-ERISA nature of the component part of the Plan);

WHEREAS, Michigan Gutters, Inc. wishes to amend and restate these programs accordingly; now, therefore it is **RESOLVED**, that the Comprehensive Health and Welfare Benefits Plan (the "Plan") for Michigan Gutters, Inc. is hereby adopted to read as set forth in the document entitled "Comprehensive Health and Welfare Benefits Plan and Summary Plan Description Information for Michigan Gutters, Inc., in substantially the form attached to this consent; and **RESOLVED**, that the officers of Michigan Gutters, Inc., or any one of them, are each hereby authorized to execute the Plan and any and all other documents, and to take such other action, which is necessary or convenient to effectuate the foregoing resolutions.

Proposal#: Plan: 1001 89092

Companion Life Insurance Company

Effective Date: 06/01/2018

dental by design

Plan Design - Modified Select

Region: 336
State: Michigan

	Michigan Gutters ***Group# 336 14 06401 000***
Program Deductible Per Individual Family Limit Waived for Type I service?	 $100 Lifetime Deductible No Limit No
Type I **Preventive Services**	100% oral exams, cleanings, (2 per 12 months), bitewing x-rays (1 per 12 months). space maintainers. pain treatment, sealants. full mouth x-rays
Type II **Basic Services** **Benefit Waiting Period**	80% fillings, anesthesia, simple&surgical extractions, endodontics, oral surgery periodontics None
Type III **Major Services** **Benefit Waiting Period**	50% crowns, inlays, onlays dentures, bridges, implants, perio trays 12 months
Maximums	$ 1000 **Calendar** Year
Type IV Orthodontia **Child(ren) Only**	Not Selected

Disclaimer: This is a summary of benefits only. Please refer to the policy for comprehensive benefit details. Payment is based upon allowable charges in the area in which the service is rendered. Any dentist charge above the allowable charge is not a covered expense.

LIMITATIONS

I. COVERED EXPENSES WILL NOT INCLUDE, AND NO BENEFITS WILL BE PAYABLE:

1. For Class III and Class IV Procedures in the first 12 months that a person is insured, except as may be provided in the Takeover Benefits provision. This exclusion does not apply to Incentive Plans.
2. For any treatment which is for cosmetic purposes, or to correct congenital malformations other than medically necessary treatment of congenital cleft in the lip or palate, or both.
3. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. Replacement of an existing implant supported prosthetic device is covered only once every ten (10) years from the placement date of such device and only then if it is unserviceable and cannot be made serviceable. However if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under this policy, it will be a covered expense.
4. For initial placement of any prosthetic appliance, implants or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Insured is covered under this policy. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
5. For any procedure begun before coverage begins or after the Insured's coverage terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's coverage terminates.
6. To replace lost or stolen appliances.
7. For appliances, restorations, or procedures to:
   a. alter vertical dimension;
   b. restore or maintain occlusion;
   c. splint or replace tooth structure lost as a result of abrasion or attrition
   d. treat disturbances of the temporomandibular joint.
8. Charges for a missed appointment, consultations or for completion of claim forms.
9. If applicable, orthodontia covered charges will not include charges for services:
   a. payable under any other provisions or policy
   b. rendered in the first 12 months the insured person is covered under the policy
   c. incurred by employee or spouse, or incurred by dependent children after reaching the age of 19 (unless adult and child(ren) orthodontia option is selected)
10. For sealants which are:
    a. not applied to a permanent molar
    b. applied after attaining age 16
    c. reapplied to a molar within three years from the date of a previous sealant application
11. For application of fluoride after attaining age 19.
12. Because of an injury arising out of, or in the course of, work for wage or profit or eligible for benefits under Worker's Compensation.
13. For services which are not recommended by a dentist or which are not required for necessary care and treatment.
14. For services related to equilibration, bite registration or bite analysis.
15. Crowns for the purpose of periodontal splinting.
16. Charges for any precision or semi-precision attachments, and any endodontic treatment associated with it, or other customized attachments.
17. For procedures not identified on the List of Dental Procedures in the Master Policy.
18. No benefit will be provided for implants or implant services where loss of the tooth was prior to the Insured's effective date of coverage under this dental plan.

II. PAYMENT FOR SERVICES SHALL BE LIMITED AS FOLLOWS:

If this plan replaces another plan of similar benefits and as a result offers takeover benefits, we limit what we pay to the lesser of;
a. what the prior plan would have paid, or
b. what this plan would usually pay.
We will deduct any benefits actually paid by the prior plan under any extension provision.

Blue Care Network of Michigan

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

BCN HSA Bronze $6650 0%

MICHIGAN GUTTERS INC

Coverage Period: Beginning on or after 06/01/2019

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

Coverage for: All Contract Types **Plan Type:** HMO

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 1-800-662-6667 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at (https://www.healthcare.gov/sbc-glossary) or call 1-800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$6,650/$13,300	Generally, you must pay all of the costs from provider's up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine maternity care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/)
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$6650/$13300	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See (www.BCBSM.com) or call the phone number on the back of your ID card for a list of network providers. 1-800-662-6667 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	None
	Specialist visit	No charge	Not covered	Requires referral/30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge, Deductible does not apply	Not covered	Deductible does not apply to preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require preauthorization to non-preventive services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires preauthorization
http://**If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at (www.bcbsm.com/2019selectdruglist)	Tier 1A - Preferred Generics	No charge	Not covered	/Any overall deductible/out-of-pocket maxes apply. 90 day mail order prescriptions are covered in full after deductible has been met.
	Tier 1B - Generics	No charge	Not covered	
	Tier 2 - Preferred Brand	No charge	Not covered	
	Tier 3 - Non-Preferred Brand	No charge	Not covered	
	Tier 4 - Preferred Specialty	No charge	Not covered	Limited to a 30 day supply
	Tier 5 - Non-Preferred Specialty	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require preauthorization/50% coinsurance for weight reduction, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. 50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	No charge	Not covered	See "Hospital stay facility fee"
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No charge	Not covered	Preauthorization is required
	Inpatient services	No charge	Not covered	Preauthorization is required
If you are pregnant	Office visits	No charge for routine prenatal	Not covered	Deductible does not apply to routine maternity services
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	No charge	Not covered	Requires preauthorization/Limited to 30 visits per calendar year for PT/OT combined / 30 visits per calendar year for speech therapy/30 visits per calendar year for pulmonary/cardiac.
	Habilitation services	No Charge	Not covered	Requires preauthorization/limited to 30 visits per calendar year for PT/OT combined. 30 visits per calendar year for speech therapy.
	Skilled nursing care	No charge	Not covered	Requires preauthorization/Limited to 45 days per calendar year. Custodial care not covered.
	Durable medical equipment	50% coinsurance	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full.
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	No Charge	Difference between the BCN approved amount and the amount charged by the provider.	Limited to once in a calendar year through the last day of the year in which the individual turns age 19
	Children's glasses	No Charge	Difference between the BCN approved amount and the amount charged by the provider.	Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which the individual turns age 19.
	Children's dental check-up	Contact your benefit administrator for coverage information.	Contact your benefit administrator for coverage information.	None

Excluded Services & Other Covered Services:

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

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

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

- Bariatric surgery (Limited to one per lifetime. Requires preauthorization)
- Chiropractic care
- Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

Your Rights to Continue Coverage:

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

Your Grievance and Appeals Rights:

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

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

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

Does this Plan Provide Minimum Essential Coverage? Yes

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

Does this Plan Meet the Minimum Value Standard? Yes

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

Translation available

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$6650
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,710**

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

The plan's overall deductible	$6650
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$6,710**

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

The plan's overall deductible	$6650
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

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

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

[illegible] 877-469-2583 TTY:711 [illegible]

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

Blue Care Network of Michigan

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

BCN Silver $3500 30%

MICHIGAN GUTTERS INC

Coverage Period: Beginning on or after 06/01/2019

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

Coverage for: All Contract Types **Plan Type:** HMO

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 1-800-662-6667 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at (https://www.healthcare.gov/sbc-glossary) or call 1-800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$3,500/$7,000	Generally, you must pay all of the costs from provider's up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Lab, preventive care, DME/P&O, diabetic supplies, PCP office visits, specialist office visits, urgent care, allergy injections, prescription drugs, outpatient mental health and substance use services	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/)
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$7,900/$15,800	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See (www.BCBSM.com) or call the phone number on the back of your ID card for a list of network providers. 1-800-662-6667 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit. Deductible does not apply	Not covered	Only the PCP office visit is exempt from the deductible. Other services received in the office, deductible applies. $40 copay for online visits.
	Specialist visit	$60 copay/visit. Deductible does not apply	Not covered	Requires referral. $5 copay for allergy injections/50% coinsurance for allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician /Deductible applies for allergy testing
	Preventive care/screening/immunization	No charge. Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance. Lab services covered in full. Deductible does not apply to lab services	Not covered	May require preauthorization / No charge for lab services
	Imaging (CT/PET scans, MRIs)	$150 copay	Not covered	Requires preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at (www.bcbsm.com/2019selectdruglist)	Tier 1A - Preferred Generics	$15 copay/30 days. Deductible does not apply	Not covered	Prior-auth & step therapy may apply Drugs for sexual dysfunction, weight loss, cough & cold and compounds are excluded No charge for Tier 1A contraceptives. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10.
	Tier 1B - Generics	$40 copay/30 days. Deductible does not apply	Not covered	
	Tier 2 - Preferred Brand	$60 copay/30 days. Deductible does not apply	Not covered	
	Tier 3 - Non-Preferred Brand	$80 copay/30 days. Deductible does not apply	Not covered	
	Tier 4 - Preferred Specialty	20% coinsurance. Deductible does not apply	Not covered	$200 copay max.Limited to a 30 day supply
	Tier 5 - Non-Preferred Specialty	20% coinsurance. Deductible does not apply	Not covered	$300 copay max.Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	May require preauthorization/50% coinsurance for weight reduction procedures,TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	30% coinsurance	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Copay waived if admitted
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergent transport is covered when preauthorized
	Urgent care	$60 copay/visit. Deductible does not apply	$60 copay/visit. Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Preauthorization is required. 50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	No charge	Not covered	See "Hospital stay facility fee"
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$40 copay/visit. Deductible does not apply	Not covered	Preauthorization is required
	Inpatient services	30% coinsurance	Not covered	Preauthorization is required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge. Deductible does not apply	Not covered	Postnatal and non-routine prenatal office visits-$40 copay. Only the routine prenatal visit is exempt from the deductible. Other services, deductible applies
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	30% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	Not covered	None
	Rehabilitation services	$60 copay/visit	Not covered	Requires preauthorization/limited to 30 visits per calendar year for PT/OT combined/30 visits per calendar year for speech therapy./30 visits per calendar year for pulmonary/cardiac.
	Habilitation services	ABA - $40 copay per visit. $60 copay per visit for PT/OT/ST. Deductible does not apply to ABA services	Not covered	Requires preauthorization/limited to 30 visits per calendar year for PT/OT combined. 30 visits per calendar year for speech therapy.
	Skilled nursing care	30% coinsurance	Not covered	Requires preauthorization/Limited to 45 days per calendar year
	Durable medical equipment	50% coinsurance. Deductible does not apply	Not covered	Must be authorized and obtained from a BCN supplier Diabetic supplies covered with 30% coinsurance. Deductible does not apply to diabetic supplies
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Difference between the BCN approved amount and the amount charged by the provider.	Limited to once in a calendar year through the last day of the year in which the individual turns age 19
	Children's glasses	No Charge	Difference between the BCN approved amount and the amount charged by the provider.	Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which the individual turns age 19.
	Children's dental check-up	Contact your benefit administrator for coverage information.	Not Covered	Contact your benefit administrator for coverage information.

Excluded Services & Other Covered Services:

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

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

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

- Bariatric surgery (Limited to one per lifetime. Requires preauthorization)
- Chiropractic care
- Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

Your Rights to Continue Coverage:

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

Your Grievance and Appeals Rights:

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

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

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

Does this Plan Provide Minimum Essential Coverage? Yes

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

Does this Plan Meet the Minimum Value Standard? Yes

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

Translation available

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$3500
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$100
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,660**

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

The plan's overall deductible	$3500
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,060**

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

The plan's overall deductible	$3500
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

ئەگەر تۆ يان كەسێك كە يارمەتى دەدەيت پێويستى بە يارمەتى هەيە، مافى ئەوەت هەيە بە خۆڕايى يارمەتى و زانيارى پێويست بە زمانەكەت وەربگريت. بۆ قسەكردن لەگەڵ وەرگێڕ، پەيوەندى بە ژمارەى خزمەتگوزارى كڕيارانەوە بكە كە لەپشت كارتەكەتدا هەيە، يان 877-469-2583 TTY:711 بكە ئەگەر ئێستا ئەندام نيت.

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

BASIC and SUPPLEMENTAL GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Approximately 50 million households recognize they need more life insurance (40 percent of households).[1]

MICHIGAN GUTTERS

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer gives extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life and AD&D insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

APPLICANT	BASIC COVERAGE	SUPPLEMENTAL COVERAGE
Employee	Benefit[2]: $25,000 AD&D: Included	Benefit[2]: Increments of $10,000 Maximum: the lesser of 3x earnings or $250,000 AD&D: Included
Spouse	Not Included	Benefit [1]: Increments of $5,000 Maximum: the lesser of 50% of your supplemental coverage or $25,000 AD&D: Included
Child(ren)	Not Included	Benefit: $10,000 AD&D: Included

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT

Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.

LOSS FROM ACCIDENT	BASIC COVERAGE	SUPPLEMENTAL COVERAGE
Life	100%	100%
Both Hands or Both Feet or Sight of Both Eyes	100%	100%
One Hand and One Foot	100%	100%
Speech and Hearing in Both Ears	100%	100%
Either Hand or Foot and Sight of One Eye	100%	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%	100%
Movement of Both Lower Limbs (Paraplegia)	75%	75%
Movement of Three Limbs (Triplegia)	75%	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%	50%
Either Hand or Foot	50%	50%
Sight of One Eye	50%	50%
Speech or Hearing in Both Ears	50%	50%
Movement of One Limb (Uniplegia)	25%	25%

[2]Your benefit will be reduced by 50% at age 70.

Thumb and Index Finger of Either Hand	25%	25%

PREMIUMS

Your employer pays 100% of the premium for your (employee) basic coverage. Your contribution for voluntary coverage is shown on the Premium Worksheet. [3]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 19 (or under age 25 if a full-time student).

AM I GUARANTEED COVERAGE?

Basic insurance is guaranteed issue coverage – it is available without having to provide information about your health.

If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $100,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

For your spouse coverage, if you are newly eligible, this coverage is offered without requiring your spouse to provide evidence of insurability. If you were previously eligible and are electing coverage for the first time or electing to increase your spouse's current coverage, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Supplemental insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

AD&D is available without having to provide information about your or your family's health.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Your employer pays 100% of the premium for your (employee) basic coverage.

Premiums for supplemental coverage are provided on the Premium Worksheet. You have a choice of coverage amounts. You may elect supplemental insurance for you only, or for you and your dependent(s).

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for basic coverage. If you have not already done so, you must designate a beneficiary.

You may enroll in supplemental coverage during any scheduled enrollment period, or within 31 days of the date you have a change in family status, .

WHEN DOES THIS INSURANCE BEGIN?

Basic insurance will become effective for you on the date you become eligible.

Supplemental insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate. Conversion and portability are not available for AD&D coverage.

[1]LIMRA, Facts About Life 2016. Web. 30 June 2017. <https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf>
[3]Rates and/or benefits may be changed. Rates are based on the age of the insured person and increase on the policy anniversary date on or following your birthday as you enter each new age category.

Prepare. Protect. Prevail. With The Hartford. ®

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your benefit will be reduced by 35% at age 65 and 50% at age 70. Reductions will be applied to the original amount.
- A benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your benefit will be reduced by 35% at age 65 and 50% at age 70. Reductions will be applied to the original amount.
- This insurance does not cover losses caused by:
  - Sickness; disease; or any treatment for either
  - Any infection, except certain ones caused by an accidental cut or wound
  - Intentionally self-inflicted injury, suicide or suicide attempt
  - War or act of war, whether declared or not
  - Injury sustained while in the armed forces of any country or international authority
  - Injury sustained on aircraft in certain circumstances
  - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
  - Injury sustained while riding, driving, or testing any motor vehicle for racing
  - Injury sustained while committing or attempting to commit a felony
  - Injury sustained while driving while intoxicated
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Child(ren) may only be covered as a dependent of one employee.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you or your dependent(s) have coverage.

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This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.