



Choice Schools Associates – Effective 07/10/10
#48282/001/002/003/004/005/010/011/012/013
Community BlueSM PPO Plan / Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

In-network

Out-of-network

Member’s responsibility (deductibles, copays and dollar maximums)

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a “low access area” by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider’s charge.

	In-network	Out-of-network
Deductibles	None	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year
Copays		
<ul style="list-style-type: none"> Fixed dollar copays 	<ul style="list-style-type: none"> \$20 copay for office visits \$50 copay for emergency room visits 	\$50 copay for emergency room visits
<ul style="list-style-type: none"> Percent copays 	50% of approved amount for private duty nursing See “Mental health care and substance abuse treatment” section for mental health and substance abuse percent copay amounts.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 20% of approved amount for most other covered services See “Mental health care and substance abuse treatment” section for mental health and substance abuse percent copay amounts.
Copay dollar maximums		
<ul style="list-style-type: none"> Percent copay maximums – includes general medical only – excludes fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays 	Not applicable	\$2,000 for one member, \$4,000 for two or more members each calendar year
<ul style="list-style-type: none"> For groups of 51 or more employees (including seasonal and part-time) that are subject to the MHP law, copays for mental health care and substance abuse treatment are subject to a separate copay maximum 	Not applicable	\$2,000 for one member, \$4,000 for two or more members each calendar year
Dollar maximums	\$1 million lifetime maximum per covered specified human organ transplant type and a separate \$5 million lifetime maximum per member for all other covered services and as noted for individual services	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.



In-network

Out-of-network

Preventive care services – *Payment for preventive services is limited to a **combined** maximum of \$500 per member per calendar year

Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

Mammography

Mammography screening	Covered – 100%	Covered – 80% after deductible
One per calendar year, no age restrictions		

Physician office services

Office visits	Covered – \$20 copay per office visit	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – \$20 copay per office visit	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – \$20 copay per office visit	Covered – 80% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$50 copay per visit (copay waived if admitted or for an accidental injury)	Covered – \$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 100%	Covered – 100%

Diagnostic services

Laboratory and pathology services	Covered – 100%	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic radiology	Covered – 100%	Covered – 80% after deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	



In-network

Out-of-network

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 100%	Covered – 80% after deductible
	Unlimited days	
Inpatient consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

Alternatives to hospital care

Skilled nursing care	Covered – 100%	Covered – 100%
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 100%	Covered – 100%
Home infusion therapy – must be medically necessary	Covered – 100%	Covered – 100%

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 100%	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100%	Covered – 80% after deductible
Voluntary sterilization	Covered – 100%	Covered – 80% after deductible

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities only
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100%	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100%	Covered – 80% after deductible



In-network

Out-of-network

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See “Copay dollar maximums” section for these amounts. If you are employed by a union group with a collective bargaining agreement, please contact your employer to determine if this benefit level applies to you.

Inpatient mental health care	Covered – 100%	Covered – 80% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 100%	Covered – 80% after deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic • Physician’s office	Covered – 100%	Covered – 80% after deductible
	Covered – 100%	Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities only	Covered – 100%	Covered – 80% after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – \$20 copay per office visit	Covered – 80% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered – 80% after deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%	Covered – 100%
Private duty nursing	Covered – 50%	Covered – 50%

Additional riders

Rider XVA , excludes voluntary abortions	Excludes benefits for voluntary abortions.
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Choice Schools Associates – Effective 07/10/10 #48282/008/101/102/103/104/105/110/111/112/113 Community BlueSM PPO – Plan / Benefits-at-a-Glance

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In-network

Out-of-network

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

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

	In-network	Out-of-network
Deductibles	\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible waived if service is performed in a PPO physician's office.	\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed dollar copays	\$20 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
• Percent copays	20% for general services (copay waived if service is performed in a PPO physician's office) and 50% for mental health care, substance abuse treatment and private duty nursing	40% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
Copay dollar maximums		
• Fixed dollar copays	None	None
• Percent copays – excludes mental health care, substance abuse treatment and private duty nursing copays	\$1,500 for one member, \$3,000 for two or more members each calendar year	\$3,000 for one member, \$6,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Dollar maximums	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services	

Preventive care services – *Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year

Service	In-network	Out-of-network
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

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In-network

Out-of-network

Mammography

Mammography screening	Covered – 80% after deductible	Covered – 60% after deductible
One per calendar year, no age restrictions		

Physician office services

Office visits	Covered – \$20 copay per office visit	Covered – 60% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office consultations	Covered – \$20 copay per office visit	Covered – 60% after deductible, must be medically necessary
Urgent care visits	Covered – \$20 copay per office visit	Covered – 60% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$50 copay per visit (copay waived if admitted or for an accidental injury)	Covered – \$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

Diagnostic services

Laboratory and pathology services	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic tests and x-rays	Covered – 80% after deductible	Covered – 60% after deductible
Therapeutic radiology	Covered – 80% after deductible	Covered – 60% after deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100%	Covered – 60% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after deductible	Covered – 60% after deductible
	Includes delivery provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible

Alternatives to hospital care

Skilled nursing care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Home infusion therapy – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 80% after deductible	Covered – 60% after deductible
Presurgical consultations	Covered – 100%	Covered – 60% after deductible
Colonoscopy	Covered – 80% after deductible	Covered – 60% after deductible
Voluntary sterilization	Covered – 80% after deductible	Covered – 60% after deductible

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In-network

Out-of-network

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities only
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after deductible	Covered – 60% after deductible
Specified oncology clinical trials	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, cornea and skin transplants	Covered – 80% after deductible	Covered – 60% after deductible

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See “Copay dollar maximums” section for these amounts. If you are employed by a union group with a collective bargaining agreement, please contact your employer to determine if this benefit level applies to you.

Inpatient mental health care	Covered – 100%	Covered – 80% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 100%	Covered – 80% after deductible
	Unlimited days	
Outpatient mental health care		
	<ul style="list-style-type: none"> Facility and clinic Physician’s office 	Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities only	Covered – 100%	Covered – 80% after deductible
	Covered – 100%	Covered – 80% after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible	Covered – 60% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – \$20 copay per office visit	Covered – 60% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 80% after deductible	Covered – 60% after deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and orthotic appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible

Additional riders

Rider XVA , excludes voluntary abortions	Excludes benefits for voluntary abortions.
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**Choice Schools Associates – Effective 07/10/10
 #48282/001/002/003/004/005/010/011/012/013
 Blue Preferred[®] Rx Prescription Drug Coverage
 with \$10 Generic / \$40 Formulary Brand / \$80 Nonformulary Brand
 Triple-Tier Copay / Open Formulary / Benefits-at-a-Glance**

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Note: The mail order pharmacy for **specialty drugs** is Option Care, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blue members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under “I am a Member.” If you have any questions, please call Option Care customer service at 866-515-1355.

If you are enrolled in one of our integrated medical-surgical prescription drug products, your prescription drug benefits, including mail order drugs, are subject to the same deductible and lifetime dollar maximum required under your medical-surgical coverage. Benefits are not payable until after you have met the annual deductible. After you have satisfied the deductible you are required to pay the copays listed below, which may be limited to an annual out-of-pocket maximum.

		90-day retail network pharmacy	Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Member’s responsibility (copays)					
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 34 day period	\$10 copay	\$10 copay	\$10 copay	\$10 copay plus 25% of the BCBSM approved amount for the drug
	35 to 83 day period	No coverage	\$20 copay	No coverage	No coverage
	84 to 90 day period	\$20 copay	\$20 copay	No coverage	No coverage
Tier 2 – Formulary brand-name drugs	1 to 34 day period	\$40 copay	\$40 copay	\$40 copay	\$40 copay plus 25% of the BCBSM approved amount for the drug
	35 to 83 day period	No coverage	\$80 copay	No coverage	No coverage
	84 to 90 day period	\$80 copay	\$80 copay	No coverage	No coverage
Tier 3 – Nonformulary brand-name drugs	1 to 34 day period	\$80 copay	\$80 copay	\$80 copay	\$80 copay plus 25% of the BCBSM approved amount for the drug
	35 to 83 day period	No coverage	\$160 copay	No coverage	No coverage
	84 to 90 day period	\$160 copay	\$160 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

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***90-day retail network pharmacy**

****Network mail order provider**

Network pharmacy (not part of the 90-day retail network)

Non-network pharmacy

Covered services

	*90-day retail network pharmacy	**Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
"Rx only" drugs	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled drugs	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 75% less plan copay for the insulin or other covered injectable legend drug

* **Note:** The member must have been on the medication, under BCBSM coverage, for at least 60 days out of the previous 120 days before being eligible for the 90-day supply.

** **Note:** We will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Features of your plan

Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy , an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Only claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com . Log in under "I am a Member" and click on "Prescription Drugs."
Mandatory maximum allowable cost (MAC) drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you MUST pay the difference in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug plus your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay.
Physician-administered injectable drugs	Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com . If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com .

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Additional riders

<p>Rider PD-XED, excludes elective drugs</p>	<p>Excludes coverage for elective drugs. Note: Elective drugs are lifestyle drugs such as those that treat sexual impotency or infertility, help in weight loss or help to stop smoking. They are not designed to treat acute or chronic illnesses or prescribed for medical conditions that have no demonstrable physical harm if not treated.</p>
<p>Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and “Rx only” oral or injectable contraceptive medications. Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>



**Choice Schools Associates – Effective 07/10/10
 #48282/008/101/102/103/104/105/110/111/112/113
 Blue Preferred[®] Rx Prescription Drug Coverage with \$15 / \$50
 50% / \$70 minimum / \$100 maximum / Nonformulary Brand Name
 Triple-Tier Copay / Open Formulary / Benefits-at-a-Glance**

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Note: Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blue members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Option Care customer service at 866-515-1355.

If you are enrolled in one of our integrated medical-surgical prescription drug products, your prescription drug benefits, including mail order drugs, are subject to the same deductible and lifetime dollar maximum required under your medical-surgical coverage. Benefits are not payable until after you have met the annual deductible. After you have satisfied the deductible you are required to pay the copays listed below, which may be limited to an annual out-of-pocket maximum.

		90-day retail network pharmacy	Network mail order provider	Network pharmacy (not part of the 90- day retail network)	Non-network pharmacy
Member's responsibility (copays)					
Tier 1 – Generic or prescribed over-the- counter drugs	1 to 34-day period	\$15 copay	\$15 copay	\$15 copay	\$15 copay plus 25% of the BCBSM approved amount for the drug
	35 to 83-day period	No coverage	\$30 copay	No coverage	No coverage
	84 to 90-day period	\$30 copay	\$30 copay	No coverage	No coverage
Tier 2 – Formulary brand-name drugs	1 to 34-day period	\$50 copay	\$50 copay	\$50 copay	\$50 copay plus 25% of the BCBSM approved amount for the drug
	35 to 83-day period	No coverage	\$100 copay	No coverage	No coverage
	84 to 90-day period	\$100 copay	\$100 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

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***90-day retail network pharmacy**

****Network mail order provider**

Network pharmacy (not part of the 90-day retail network)

Non-network pharmacy

Member's responsibility (copays), *continued*

Tier 3 – Nonformulary brand-name drugs	1 to 34-day period	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100 plus 25% of the BCBSM approved amount for the drug
	35 to 83-day period	No coverage	\$140 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
	84 to 90-day period	\$140 or 50% of the approved amount (whichever is greater), but no more than \$200	\$140 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage

Covered services

"Rx only" drugs	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled drugs	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 75% less plan copay for the insulin or other covered injectable legend drug

* **Note:** The member must have been on the medication, under BCBSM coverage, for at least 60 days out of the previous 120 days before being eligible for the 90-day supply.

** **Note:** We will not pay for drugs obtained from non-network mail order providers, including Internet providers.



Features of your plan

<p>BCBSM custom formulary</p>	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ Tier 1 (generic) – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ Tier 2 (formulary brand) – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. ▪ Tier 3 (nonformulary brand) – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.
<p>Mandatory preauthorization</p>	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy, an initial step in the “Prior Authorization” process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Only claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com. Log in under “I am a Member” and click on “Prescription Drugs.”</p>
<p>Mandatory maximum allowable cost (MAC) drugs</p>	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you MUST pay the difference in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug plus your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay.</p>
<p>Physician-administered injectable drugs</p>	<p>Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.</p>
<p>Drug interchange and generic copay waiver</p>	<p>Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
<p>Quantity limits</p>	<p>Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com.</p>



Additional riders

<p>Rider PD-XED, excludes elective drugs</p>	<p>Excludes coverage for elective drugs. Note: Elective drugs are lifestyle drugs such as those that treat sexual impotency or infertility, help in weight loss or help to stop smoking. They are not designed to treat acute or chronic illnesses or prescribed for medical conditions that have no demonstrable physical harm if not treated.</p>
<p>Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and “Rx only” oral or injectable contraceptive medications. Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>

Group Dental Insurance

SUMMARY OF BENEFITS

Sponsored by: Choice Schools Associates

Effective date: July 1, 2010

- You may choose any dentist. However, using dentists participating in the network should lower your out-of-pocket expenses. You do not need a referral to see a specialist.
- A list of participating dentists may be accessed at www.LincolnFinancial.com.
- By enrolling in the dental plan you and your enrolled family members will have access to *Lincoln DentalConnect*SM, our free on-line dental health information Web site.
- If you incur dental expenses and have satisfied the benefit waiting period(s), the plan pays the following percentage of allowable expenses in excess of the deductible up to the maximum benefit.
- Covered dental expenses include only those services listed in your certificate.
- Covered expenses outside the panel service area will not exceed the policy's usual and customary allowances.

		In-Network	Out-of-Network
Preventive	Services include routine exams, X-rays, teeth cleanings (prophylaxis), sealants, fluoride treatments for children and space maintainers.	100%	100%
Basic	Services include fillings, root canal therapy, periodontal surgery and periodontal maintenance procedures, consultations, extractions and most oral surgeries; emergency relief of dental pain and, when necessary, general anesthesia and I.V. sedation; prefabricated stainless steel and resin crowns and repair of bridgework and dentures.	80%	80%
Major	Services include crowns, bridges and dentures, to replace natural teeth extracted or lost while covered.	50%	50%
Orthodontics	Child coverage includes orthodontic exams, orthodontic x-rays, orthodontic extractions, study models and orthodontic appliances.	50%	50%
Deductible	Calendar year deductible. Waived for Preventive services.	\$0 Individual \$0 Family	\$0 Individual \$0 Family
Maximum	Calendar year maximum for Preventive, Basic, and Major services:	\$1,000	\$1,000
Ortho Maximum	Lifetime Ortho Maximum for children:	\$1,000	\$1,000

Enrolling for coverage

If you do not want to enroll at this time, submit the completed waiver form to your plan administrator. If you waive coverage now and want to enroll at a later date, you will be subject to the plan's Late Entrant provision.

Dependent eligibility

Unmarried dependent children may be covered to age 26, if a full-time student.

Benefit waiting period

Basic services: None
 Major services: None
 Orthodontics: None

If prior carrier credit is included

- Available to employees and dependents if your coverage was active on the date your employer's prior dental plan terminated, and if you are covered by this plan on its effective date.
- Credit will be given for dental expenses incurred toward satisfying your deductible under your employer's prior dental plan during the same calendar year.
- Credit will be given for the time you have been covered by your employer's prior dental plan toward the satisfaction of benefit waiting periods.

Exclusions

This is a summary of policy exclusions. The policy contains other, more specific, exclusions and limitations not fully explained in this benefit summary.

- The plan does not cover services started before coverage begins or after it ends. Services must be necessary and appropriate for the claimant's condition. Benefits are limited to services specifically shown on the list of procedures included in the policy, unless coverage for additional services is required by state law. Benefits are not payable for duplication of services or for treatment by a practitioner who lives with or is related to the employee or dependent.
- Benefits are not payable for placement of a prosthetic, unless it is needed to replace teeth extracted while covered. Installation, maintenance or removal of implants or any related expense is excluded. Policy does not cover the cost of athletic mouth guards, appliances to correct harmful habits or the replacement of lost or stolen dental appliances. Policy excludes services for treatment of TMJ or congenital malformations, except as required by law.
- Benefits are not payable for veneers, cosmetic procedures or medications administered outside the dentist's office, for prescription drugs, or for analgesia, sedation, hypnosis or acupuncture administered for the purposes of alleviating anxiety or apprehension. Nitrous oxide is not covered.
- Plan benefits are not payable for a condition for which the claimant is eligible for benefits under worker's compensation or a similar law; or for a condition attributed to employment or military service. Coverage is not available for dental conditions caused by an act of war, self-inflicted injury, involvement in an illegal occupation, attempt to commit a felony, or active participation in a riot.
- If benefits for orthodontia are included, the plan does not cover any treatment plan started before coverage begins or during the benefit waiting period unless the member was receiving orthodontia benefits from this employer's previous group dental policy. In that case, Lincoln Financial will continue orthodontia benefits until the combined benefit paid by the two policies is equal to this policy's lifetime orthodontia.

Alternative benefits provision

In certain situations there may be two or more methods of treating a dental condition. Your policy includes an alternative benefits provision that may reduce benefits to the lowest cost, generally effective and necessary form of treatment. For example, the policy covers amalgam fillings on posterior teeth even if tooth-colored fillings are used.

Late entrants

If you enroll more than 31 days after becoming eligible, you will be subject to the plan's Late Entrant limitation and Prior Carrier Credit will not be available.

Predetermination of benefits

Allows you to find the amount covered prior to having a dental procedure. We recommend that you use this service when expenses are expected to exceed \$300.

Claim submission

Submit a claim by mail to:

Lincoln Financial Group
Dental Claims Input Center
P.O. Box 2640
Omaha, NE 68103-2640

Submit a claim by fax to:

(877) 843-3945

For assistance or additional information

Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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Your VSP Vision Benefits Summary

Welcome to VSP® Vision Care. Your VSP vision benefit offers you the best in eyecare and eyewear.

Personalized Care. A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Eyewear. Choose the eyewear that's right for you and your budget. From classic styles to the latest designer frames, you'll find the eyewear that's right for you and your family.

Choice of Providers. With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Using your VSP benefit is easy.

- **Find the right eyecare provider for you.** To find a VSP doctor, visit vsp.com or call 800.877.7195.
- **Review your benefit information.** Visit vsp.com to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card required.

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

For your complete benefit description, visit vsp.com or call 800.877.7195.

Choice Schools Associates and VSP provide you an affordable eyecare plan.

Doctor Network.....VSP Signature

Your Coverage with a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness

- \$10.00 copay **every 12 months**

Prescription Glasses

- \$25.00 copay

Lenses..... **every 12 months**

- *Single vision, lined bifocal, lined trifocal lenses and tints*
- *Polycarbonate lenses for dependent children*

Frame..... **every 12 months**

- \$130.00 allowance for frame of your choice
- 20% off the amount over your allowance

~OR~

Contact Lens Care

- **No copay every 12 months**

\$130.00 allowance for contacts and the contact lens exam (fitting and evaluation).

Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of lenses.

Extra Discounts and Savings

Glasses and Sunglasses

- Average 35 - 40% savings on all non-covered lens options
- 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam

Contacts

- 15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Your Coverage with Other Providers

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

Exam	Up to \$35.00
Single vision lenses	Up to \$25.00
Lined bifocal lenses	Up to \$40.00
Lined trifocal lenses	Up to \$55.00
Tints.....	Up to \$5.00
Frame	Up to \$45.00
Contacts	Up to \$105.00

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.



Group Life Insurance

Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: Choice Schools Associates

Life Benefit	Employee
Amount	\$50,000
Guarantee Issue	\$50,000
AD&D Benefit	Employee
Amount	\$50,000
Guarantee Issue	\$50,000
Benefit Reduction	Employee
Benefits will reduce:	35% at age 65 An additional 25% of the original amount at age 70; and An additional 15% of the original amount at age 75 Benefits terminate at retirement
Additional Benefits	Employee
See Definitions page for:	Accelerated Death Benefit
See Definitions page for:	Seat Belt, Airbag, and Common Carrier
See Definitions page for:	Conversion
Eligibility	Employee
	All full-time active employees working 35 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.

(Please see other side)

Definitions

Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance and it will be provided at your own expense.
Seat Belt, Airbag, Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.

Additional Benefits

<i>BeneficiaryConnect</i>SM	Support services for beneficiaries who have experienced a loss.
<i>TravelConnect</i>SM	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information

Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

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Group Short-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: Choice Schools Associates

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

Eligibility	All full-time active employees working 35 or more hours per week in an eligible class are eligible for coverage.
Maximum Weekly Benefit	66.67% of weekly salary up to \$400 per week
Maximum Benefit Duration	26 weeks
Elimination Period	Benefits begin on: 1 ST day for an accident 8 TH day for an illness
Benefit Reductions	Your benefits may be reduced if: <ul style="list-style-type: none">• You are receiving benefits from any compulsory benefit, act, or law, such as a state disability plan.• You are receiving sick leave pay from your employer.
Pre-Existing Condition	None

(Please see other side)

Understanding Your Benefits

Total Disability	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Partial Disability	You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within two weeks of returning to work, you will begin receiving benefits again immediately.
Pre-Existing Condition	Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: <ul style="list-style-type: none">• Your disability is the result of a self-inflicted injury.• You are not under the regular care of a doctor when requesting disability benefits.• Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.• You are receiving payment under a salary continuance or retirement plan sponsored by the group policyholder.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: <ul style="list-style-type: none">• Any governmental retirement system earned as a result of working for the current policyholder;• Any disability or retirement benefit received under a retirement plan;• Any Social Security, or similar plan or act, benefits;• Earnings the insured earns or receives from any form of employment.
Benefit Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information

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