MICHIGAN BAC HEALTH CARE FUND

SUMMARY PLAN DESCRIPTION

SEPTEMBER 2003

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Summary Plan Description

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INTRODUCTION

About Your Plan

For you and your fellow workers, your Employer and the Union have created a Health Care Fund, which provides a specific, dependable plan of benefits. This Plan has been constantly improved in an effort to provide the best benefits possible consistent with sound financial management of the Plan.

The Michigan BAC Health Care Fund is maintained as a result of a collective bargaining agreement, sometimes referred to as a labor contract, between your Employer and the Union.

Your Health Care Fund receives its money from Employer contributions, on dates and in amounts called for by the labor contract negotiated with the Employer by your Union. **Money is not withheld from your paycheck in order to support the Fund.**

Decisions on Plan operations and benefits are made by a Board of Trustees on which labor and management are equally represented.

Working together, the Board of Trustees establishes the eligibility rules, strives to maintain the schedule of benefits, supervises the investment of the Fund's money, and sees that the Fund is in compliance with all applicable Federal laws and regulations.

In carrying out these responsibilities, the Trustees are assisted by a team of professionals including:

The **Administrative Manager** who handless the day-to-day business activities of the Fund such as collecting employer contributions, keeping records of money received, crediting each participant's account with the correct number of hours worked, paying claims, and answering inquiries from participants about their eligibility and benefits.

The **Fund Attorney** advises the Trustees about what must be done to assure that all operations of the Fund comply with Federal and State laws.

The **Fund Consultant** assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on other matters important to the Fund's operations.

The largest part of the contributions the Funds receives is returned directly to participants in the form of benefits. Some of the contributions received are set aside for reserves. The Funds' reserves can be drawn on at times when the claims expenses exceed income.

As required by law, the Fund has an independent auditor examine the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees are required to submit annual financial statements and other reports to the U.S. Department of Labor and the Internal Revenue Service. These reports are available for inspection at the Fund Office during normal business hours.

This, then is a brief description of how your Fund was established, what its purpose is, and how it operates.

SECTION 1 – ELIGIBILITY

The Michigan BAC Health Care Fund provides benefits for you, your spouse, and your eligible dependents.

This section describes eligibility for health care and disability benefits.

Active Employees

Eligibility for active employees is determined based upon contributions made for work performed within a specific number of months.

Initial Eligibility Requirements

You will become initially eligible (i.e. eligible for the first time) on the first day of the second month following the month in which you are credited with at least 275 hours of contributions made on your behalf for work performed within a three (3) consecutive month period. You will remain eligible for one (1) month. These initial eligibility requirements apply only when an Employee is first establishing eligibility in the Fund,

> For example, if you were credited with at least 100 hours in each of the three (3) consecutive months of January through March, you would be eligible for the month of May.

Continuation and Reinstatement of Eligibility

You will continue to be eligible for three (3) consecutive months beginning with the second month following three (3) consecutive months for which contributions were received on your behalf for at least 275 hours.

> For example, if you have been credited with at least 275 hours of contributions for the months of April, May, and June, you will continue to be eligible for the months of August, September, and October.

You could also continue to be eligible for the second month following the end of a 12 consecutive month period during which contributions made on your behalf total at least 1,100 hours for work actually performed.

In addition, if you work at least 211 hours within in a three (3) consecutive month period you may be eligible to remit the difference in the hours remitted on your behalf by your employer and the 275 hours required for eligibility. The

amount of the short hours self-payment will be based upon the current hourly contribution rate for Health Care Benefits.

You will be eligible beginning with the second month following the one month bookkeeping period. You are eligible for a one (1) month period and are eligible to remit short hour self-payments for one month. Thereafter you will be required to remit a full self-payment.

If you are an active eligible participant but then are disabled by either an accident or illness and are unable to work, you will be credited with disability hours for a maximum of 26 consecutive weeks. Disability hours will be credited at five (5) hours per day, up to a maximum of 25 hours per week and a maximum of 100 hours per month. This credit is available for both occupational and non-occupational disabilities.

Employment Outside the Jurisdiction

Frequently, Bricklayers accept employment outside the jurisdiction of their local union when there is no work available locally. The Plan has entered into reciprocity agreements with many other Funds covering Bricklayers that provide for the transfer of contributions back to this Fund. In most instances you must authorize the transfer of contributions in writing. Contact the Fund Office for more information.

Weekly Disability Benefit

If you are unable to work due to a non-occupational injury or illness, and you are currently eligible, you may be entitled to receive a disability benefit during the period that you are disabled. Weekly disability benefits are payable from the first day of a disability resulting from an accident, and from the eighth day for a non-occupational disability resulting from an illness, for a maximum of 26 weeks for each disability. To receive disability benefits, you must submit a Loss of Time form to the Fund Office, completed by both you and your physician, within one (1) year of the date the injury or illness begins.

Eligibility During Periods of Unemployment

If you are an active employee and would otherwise lose your eligibility because you did not work enough hours, you may continue your eligibility through self-payments. When you are about to become ineligible, the Fund Office will notify you of your self-payment rights. To qualify for self-payments, you must be ineligible because of a lack of available employment as a Bricklayer within the jurisdiction of the Fund or because, even though you are currently working as a

Bricklayer for a contributing employer, you have not worked enough hours to remain eligible. (Work in the "jurisdiction of the Fund" means work under a collective bargaining agreement that requires Fund contribution to be made for you.) Employees who are temporarily disabled may also make self-payments to continue their coverage.

The amount of the self-payment is determined by the Board of Trustees and may be adjusted periodically.

Health Insurance Portability and Accountability

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for late enrollees). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan or other source, a certificate or proof of coverage may help you obtain coverage without a preexisting condition exclusion. If you have questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C., 20210.

The rules summarized above generally take effect at the beginning of the first plan year starting after June 30, 1997. But some plans, such as some multi-employer plans, may not have to comply with parts of these rules until the first Plan year after any pre-August 21, 1997 collective bargaining agreement expires. For example, if your employer's plan year begins on January 1, 1996, the plan is not required to give you credit for your prior coverage until January 1, 1998.

You have the right to receive a certificate of prior coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or documentation of your previous coverage. To receive a certificate, please contact the Fund Office.

Self-Employed Bricklayers

Self-employed Bricklayers who have signed a collective bargaining agreement with a participating local union may participate in the Plan, and may maintain coverage, by making contributions. Contact the Fund Office for details. Contributions must be remitted at the rate of 40 hours per week, 52 weeks per year. No self-payments are permitted.

Total and Permanent Disability Self-Payment Program

If you become totally and permanently disabled before age 65, and you are no longer receiving Fund disability benefits, you and your dependents may continue your eligibility by making self-payments. To be eligible to make self-payments, you must be receiving total and permanent disability pension benefits from one of the following sources:

1. The Michigan BAC Pension Fund; or
2. The Social Security Administration.

You must be eligible by either employer contributions or self-payments, on the date of retirement to be eligible to participate in the Total and Permanent Disability Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

You may continue your coverage under the Total and Permanent Disability Self-Payment Program until one of the following occurs:

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union;
3. You become eligible for Medicare;
4. Termination of the Total and Permanent Disability Self-Payment Program;
5. Your dependents no longer meet the definition of eligible dependent under the Plan;
6. Your death.

Participants may elect to purchase prescription drug, dental, vision and hearing coverage for an additional monthly self-payment at the time they begin making Total and Permanent Disability self-payments.

If the Totally and Permanently Disabled Participant returns to work, he may continue to remit self-payments under this program until such time as he satisfies the eligibility provisions of the Active Program. Credit may or may not be

given for hours remitted in his behalf that are not sufficient to satisfy the eligibility provisions of the Plan. It is the responsibility of the Totally and Permanently Disabled Participant to notify the Fund Office, in writing, if he returns to work so that a complete review of his status can be completed. It is also his responsibility to notify the Fund Office, in writing, when he again retires.

Early Retiree Self-Payment Program

If you retire before age 65, you and your dependents will be covered under the Early Retiree Self-Payment Program until you become eligible for Medicare, if you are receiving monthly pension benefits from one of the following sources:

1. The Michigan BAC Pension Fund; or
2. The Social Security Administration.

You must be eligible by either employer contributions or active self-payments on the date of retirement to be eligible to participate in the Early Retiree Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

You may continue your coverage under the Early Retiree Self-Payment Program until one of the following occurs:

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union;
3. You become eligible for Medicare;
4. Termination of the Early Retiree Self-Payment Program;
5. Your dependents no longer meet the definition of an eligible dependent under the Plan;
6. Your death.

Participants may elect to purchase prescription drug, dental, vision and hearing coverage for an additional monthly self-payment at the time they begin making Early Retiree self-payments.

If the Early Retiree returns to work, at the trade, he may continue to remit self-payments under this program until such time as he satisfies the eligibility provisions of the Active Program. No credit will be given for hours remitted to the Fund that are not sufficient to satisfy the eligibility provisions of the Plan. It is the responsibility of the Early Retiree to notify the Fund Office, in writing, if he returns to work. It is also his responsibility to notify the Fund Office, in writing, when he again retires.

Retiree Self-Payment Program

This program provides coverage for eligible retired participants who are eligible for Medicare, and their dependents who are eligible for Medicare. You and your dependents will be eligible for coverage under the Retiree Self-Payment Program if you are receiving monthly pension benefits from one of the following sources:

1. The Michigan BAC Pension Fund; or
2. The Social Security Administration.

You must be eligible by either employer contributions, disability hours, or active self-payments on the date of retirement to be eligible to participate in the Retiree Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

You may continue your coverage under the Retiree Self-Payment Program until one of the following occurs:

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union;
3. Termination of the Retiree Self-Payment Program;
4. Your dependents no longer meet the definition of eligible dependent under the Plan;
5. Your death.

Participants may elect to purchase prescription drug, dental, vision and hearing coverage for an additional monthly self-payment at the time they begin making Retiree self-payments.

If the Retired Participant returns to work, at the trade, he may continue to remit self-payments under this program until such time as he satisfies the eligibility provisions of the Active Program. No credit will be given for hours remitted in his behalf that are not sufficient to satisfy the eligibility provisions of the Plan. It is the responsibility of the Retired Participant to notify the Fund Office, in writing, if he returns to work. It is also his responsibility to notify the Fund Office, in writing, when he again retires.

Surviving Spouse Self-Payment Program

This program provides coverage for the surviving spouse of a deceased participant. To be eligible for the program, the participant must have been

eligible for coverage on the date of death because of employer contributions or self-payments.

The surviving spouse may continue coverage under the Surviving Spouse Self-Payment Program until one of the following occurs:

1. Remarriage of the surviving spouse;
2. Failure to remit a self-payment in the correct amount by the specified due date;
3. Termination of the Surviving Spouse Self-Payment Program.

Surviving spouses may elect to purchase prescription drug, dental, vision and hearing coverage for an additional monthly self-payment at the time they begin making surviving spouse self-payments.

All active participant self-payments are due in the Fund Office on or before the last day of the month for which it provides coverage. All retiree self-payments are due on the first day of the month for which it provides coverage. Self-payments should be made by check or money order made payable to "Michigan BAC Health Care Fund." **Coverage through the Self-Payment Program must be continuous**. Anyone eligible to participate in the Self-Payment Program who fails to make a self-payment within the prescribed time and in the proper amount for a month will not be reinstated at any time in the future unless eligibility is re-established because of employer contributions for hours worked.

Active Employees and Their Spouses Who Are Age 65 or Older

If you continue to work beyond the date you or your spouse reach age 65, you have the option of making either the Fund or Medicare your primary payor of benefits. The Fund will automatically be the primary payor unless you elect to have Medicare become the primary payor. Such an election must be in writing and filed with the Fund Office. Contact the Fund Office for more information.

Dependents

Eligible dependents include your spouse, and any unmarried children until the end of the calendar year in which they turn age 19. These can include:

- Your children by birth, legal adoption, or legal guardianship while they are in your custody and dependent on you

  Note: A Child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in

anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

- Children of your spouse while they are in the custody of and legally dependent on your spouse and reside as members of your household
- Children who do not reside with you but are your legal responsibility for the provision of medical care (e.g., children of divorced parents, etc.)
- Eligible recipients under a Qualified Medical Child Support Order

Your unmarried children who are age 19 or older, but not older than age 25, can also be eligible under the plan provided they meet the following requirements:

- Be full-time students in a recognized high school, college, university, or approved trade school for at least five months of the year
- Be entirely dependent on you for their support
- Be members of your household
- Be related to you by blood, marriage, or legal adoption

Self-payments will be required to maintain coverage for these children.

Disabled Dependents

Disabled dependents may be covered to any age if they are totally and permanently disabled before age 19, and you notify TIC of the condition in writing. The disability must be from a medically determined mental or physical condition that prevents them from being self-supporting. They must be unmarried and dependent on you for support and care. You may be required to provide verification of a dependent's total and permanent disability.

Sponsored Dependents

You may apply for coverage for your other dependents who are related by blood or marriage, or who reside in your household. Such dependents must be dependent on you for more than half their support, and must have been reported as such on your most recent income tax return. Your sponsored dependents have the same basic hospital and medical surgical benefits you have. Certain additional benefits are sometimes excluded. A self-payment is required to maintain coverage.

Cobra Continuation Coverage

On January 1, 1987, this Plan became subject to a Federal Law known as "Consolidated Omnibus Budget Reconciliation Act of 1983" (COBRA), which requires the Trustees to offer you and your eligible Dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") in certain instances where coverage in the Plan would otherwise end. The COBRA regulations establish minimum time periods and conditions for the right to continue coverage; it does not change the Eligibility Rules approved by the Trustees in cases where the Rules are equal or better than the COBRA requirements.

Employee

If you are an eligible Employee, you can choose continuation coverage for up to eighteen (18) months if you lose eligibility due to:

1. A reduction in your hours of covered employment; or

2. The termination of your covered employment for any reason other than misconduct.

Disabled Persons

If you, as a covered employee, your spouse, or any dependent child qualifies for social security disability benefit within sixty (60) days after you loose coverage for the reasons listed above, you may purchase up to an additional eleven (11) months of COBRA (or a total of 29 months).

This additional COBRA coverage may be purchased not only for the disabled person, but also for other family members who are **not** disabled (subject to the applicable premium).

To obtain this additional COBRA coverage, the disabled person (employee, spouse, or dependent child) must be determined eligible for social security benefits before the end of the eighteen (18) month continuation coverage period and must notify the Fund Office during the eighteen (18) month period and within sixty (60) days after the Social Security Administration awards social security benefits to the disabled person.

The Fund is permitted to charge a **higher premium** (up to 150% higher than the regular COBRA premium) for the additional COBRA coverage available to disabled persons and their families. The higher premium applies to the disabled person and for other family members who opt for additional COBRA coverage.

Eligibility for extended COBRA coverage because of disability ends when the disabled person is deemed to no longer be disabled. Federal law requires a disabled person to notify the Fund within **thirty (30) days** after a final Social Security Administration determination that they no longer are disabled.

Spouse

If you are the Dependent spouse of an eligible Employee, you can choose continuation coverage for up to thirty-six (36) months if you lose eligibility due to:

1. The death of your spouse; or

2. A divorce or legal separation from your spouse; or

3. Termination of your eligibility because your spouse becomes eligible for Medicare.

Dependent Children

If you are the Dependent child of an eligible Employee, you can choose continuation coverage for up to thirty-six (36) months if you lose eligibility due to:

1. The death of a parent; or

2. A parent's divorce or legal separation; or

3. Termination of your eligibility because a parent becomes eligible for Medicare; or

4. Your failure to meet the definition of "Dependent child" contained in the Plan.

A newborn or adopted child will automatically be extended COBRA coverage if the parents already have COBRA coverage. This may involve an increase in the COBRA premium charged. A newborn child or an adopted child (or the child's custodian or guardian) has a right, separate from his or her parents, to elect to continue COBRA coverage for up to eighteen (18) months or thirty-six (36) months if the parent(s) are no longer entitled to COBRA.

Disabled Eligible Employee

Eleven (11) Month Extension of Continuation Coverage for Disabled Qualified Beneficiaries

If the eligible Participant is disabled (as determined by the Social Security Administration) at the time of a Qualifying Event involving termination of employment or a reduction in hours, the eighteen (18) month continuation period may be extended eleven (11) months, up to a maximum of twenty-nine (29) months for the disabled individual. The eligible Participant is responsible for electing the additional eleven (11) months of continuation coverage and notifying the Fund Office within the time frames described herein.

Notice is Required

The Employee or an eligible family member has the responsibility to inform the Fund Office within 60 days of a divorce, legal separation or a child losing dependent status.

Your Obligation

Under COBRA, a covered employee or a family member has a responsibility to notify the Fund Office, **in writing, via first class mail, or in person** about a divorce, legal separation, or a child losing dependent status under the Plan rules. Such notification should take place **immediately after** any qualifying event. If such an event is not reported to the Fund Office **within sixty (60) days** after a qualifying even occurs, COBRA coverage will not be offered.

The surviving spouse (or dependent child) of a deceased employee should contact the Fund Office **immediately after the employee's death**. Such action will help assure that continuation coverage is offered to the surviving spouse and children at the earliest possible date.

The law requires the COBRA election notice to be sent to the **last known address** on file at the Fund Office. If the election notice is sent to the wrong address due to your failure to notify the Fund Office about a change in address, the sixty (60) day time limit will not be extended and you may lose the opportunity to elect COBRA.

You are also required to notify the Fund Office **if you or any family members are covered under another group health care plan** at the time you receive a COBRA election notice (*e.g.*, if you are covered as a dependent under your spouse's plan) or if you elect COBRA, at any time you or a family member later becomes covered under another group health care plan, **including Medicare**.

The Fund Office may require you to provide information about your coverage under another group health care plan to determine whether you are entitled to elect or to continue COBRA coverage. Under certain conditions, COBRA coverage does not have to be provided if you are covered under another group health care plan. The Fund may seek reimbursement directly from you if medical expenses are paid by the Fund because you or your dependents do not notify the Fund of other health care coverage.

COBRA coverage, offered by the Plan, is as of the time such coverage is provided, is identical to the coverage provided to similarly situated beneficiaries covered by the Plan.

You and your family members do not have to show that you are insurable to purchase COBRA coverage. However, you will have to make the required self-payment(s) for such coverage in accordance with specific due dates. The amount(s) and the due date(s) will be shown on the COBRA election notice.

In addition to COBRA coverage, you will also have the option, under this Plan, **to purchase alternative coverage** which provides health care coverage equal to the COBRA coverage **plus other benefits** for a premium which is **less than the COBRA premium**. Details will appear on your COBRA Election Notice.

Application for COBRA Benefit

The Fund Office will provide you with specific instructions, rates and benefit descriptions once your notice is received and if you qualify under COBRA. Your eligibility for COBRA continuation coverage depends on you making the required payments in a timely manner. If you fail to make a timely payment of any required contribution, coverage will terminate and cannot be reinstated. Qualified beneficiaries eligible under this Section may continue only the coverage previously elected.

Limitations

In addition to the limits stated above, your rights to COBRA continuation terminate when the earliest of the following events occurs;

1. The date on which you are or become entitled to Medicare;

2. The date on which you are or become entitled to coverage under another group health program (except for coverage of a "pre-existing condition" which is excluded by the plan);

3. The date you fail to make the self-contribution in the amount and by the time required.

If more than one qualifying event occurs (such as a divorce which happens during a lay-off), the maximum continuation period is thirty-six (36) months from the date of the first qualifying event.

Only persons eligible in the Plan on the date of the original qualifying event are eligible for COBRA continuation coverage. Newly married spouses and any children (legally adopted or step-children) who were not eligible in the Plan on the date of the qualifying event cannot be added to COBRA continuation coverage.

Although an **employee's** COBRA coverage may be canceled as soon as he or she is covered by Medicare, a spouse or dependent child with COBRA coverage at that time may continue purchasing such coverage **for up to eighteen (18) or thirty-six (36) months** minus any months of COBRA coverage received immediately prior to the employee's coverage under Medicare. This option applies only if a spouse, or dependent child is not also covered by Medicare.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Omnibus Budget Reconciliation Act of 1993 requires that group health plans recognize and comply with "Qualified Medical Child Support Orders." This document sets forth the Fund's procedure for processing medical child support orders that are claimed to be Qualified Medical Child Support Orders.

Receipt of Order

The Fund Office shall promptly notify the participant and each alternate recipient (i.e., a person to receive benefits according to the Order) of the Order's receipt an the Fund's procedures for determining whether a medical child support order is a Qualified Medical Child Support Order. The Fund Office shall forward a copy of the order to Fund Counsel.

Determination of Qualification

Within a reasonable period after receipt of such Order, the Plan Administrator, with the assistance of the Fund Counsel, shall determine whether such order is a qualified medical child support order and notify the participant and each alternate recipient of such determination.

The procedures to determine whether medical child support orders are qualified medical child support orders shall follow the criteria established by Section 609 of the Employee Retirement Income Security Act of 1974, as amended and any applicable regulation and

administration actions by agencies charged to enforce Section 609. Those criteria include:

1. Inclusion of the order in a judgment order or decree made pursuant to state domestic relations law or is made pursuant to state domestic relations law or made pursuant to a law relating to medical child support described in 42 U.S.C. 1396g issued by a court of competent jurisdiction or administrative process that has the force or effect of law in the state issuing the order.

2. Creation, assignment or recognition of the right of an alternate recipient to receive Fund benefits to which a participant or a beneficiary is entitled.

3. Whether the alternate recipient is a child of the Participant or a child adopted by or placed with adoption with a participant.

4. Inclusion of the name and last known mailing address of the affected participant and the name and last known mailing address of the alternate recipient.

5. Inclusion of a description of the type of coverage to be provided by the Fund or the manner in which such coverage is to be determined.

6. Identification of the period for which the order applies.

7. Identification of the Fund as the plan to which the order supplies.

8. Verification that the order does not require the Fund to provide benefits or a form of benefits other than one provided by the Fund, provided that the Fund shall satisfy requirements of applicable laws relating to medical child support described in 42 U.S.C. 1908.

Effect of National Medical Support Notices

The Fund shall recognize as Qualified Medical Child Support Orders "National Medical Support Notices" that comply with the provisions of applicable final regulations effective March 27, 2001.

Status of Alternate Recipients

Alternate Recipients shall be deemed Fund participants for purposes of applicable reporting and disclosure requirements and shall be treated as Fund beneficiaries for all other purposes.

Direct Payments

Payments for benefits or claims for reimbursements made by Alternate Recipients under Qualified Domestic Child Support Orders shall be made to the Alternate Recipients or their legal guardians as applicable.

Notification Issues

The Fund Office shall notify an Alternate Recipient or the Alternate Recipient's legal guardian of its determination concerning a medical child support order which is claimed to be a Qualified Medical Child Support Order within a reasonable time after receipt. Alternate Recipients shall be entitled to designate a representative for the receipt of copies of notices that are sent to the alternate Recipient with respect to a medical child support order. The custodial parents or guardians of minor Alternate Recipients shall be considered their designated representatives absent an express written request of other representatives.

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ABOUT YOUR BENEFITS

The benefit portion of this booklet is designed to help you understand your current Blue Cross Blue Shield of Michigan (BCBSM) benefits and is intended to be a **general summary** of your coverage.

- **This guide is not a legal contract**. The certificates and riders that apply to your coverage, along with your application card and your BCBSM identification card, are your legal contract with BCBSM.

- The specific provisions and limitations of your coverage are presented in the certificate and riders only.

- To obtain a copy of your certificates and riders, refer to the instructions below.

This guide replaces any prior descriptions of benefit information you may have received.

While every effort has been made to make this booklet accurate and complete, your official benefits and conditions are contained in your certificates and riders. **Your certificates and riders are available on request, but they are NOT needed to obtain benefits.**

To obtain these certificates and riders, you must make your request *in writing* to:

Blue Cross Blue Shield of Michigan
Mail Code 1927
600 E. Lafayette Blvd.
Detroit, MI 48226

Be sure to include the subscriber's first and last name, address, and contract and group number as they appear on the BCBSM identification card.

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SECTION 2. HOW TO REACH BCBSM

CUSTOMER SERVICE INFORMATION

When you call or write to the BCBSM Customer Service Center, please refer to your contract number on your BCBSM ID card.

TO CALL BCBSM

Our customer service hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.

Here's how you can reach BCBSM:

Toll-Free……1-800-411-1141

BlueCard Program……..1-800-810-BLUE (2583)

To Write BCBSM

Please send all correspondence to:

Blue Cross Blue Shield of Michigan
Major Groups Customer Service Center
600 E. Lafayette Blvd, Mail Code **X420**
Detroit, MI 48226

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YOUR RESPONSIBILITIES AS A PARTICIPANT

There are certain responsibilities which you, as a participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable.

1. Take time to read this Summary Plan Description.
2. File an Employee Data (Enrollment) Card.
3. Notify the Fund Office promptly, in writing, if you have:
   a. a change of address; or
   b. a change in marital status; or
   c. a change in beneficiary; or
   d. a change in dependents.
4. Fully complete a claim form each time you submit charges for any medical expense.
5. Make self-payments on time and in the correct amount.

A detailed explanation of your responsibilities can be found in the appropriate section of the Plan Description. Please refer to the Table of Contents for page numbers.

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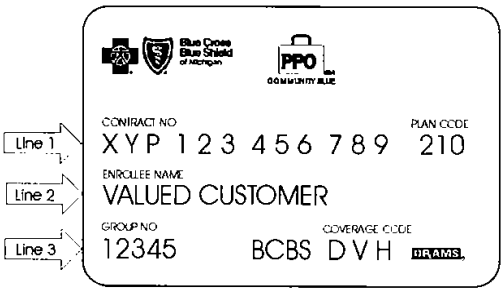
SECTION 3. GENERAL INFORMATION

Your Identification Card

Your BCBSM ID card is your key to receiving quality health care benefits. Your card will look similar to the one below:



The numbers on your personal ID card will be different from the one illustrated above.

Line 1: Contract Number (usually the subscriber's Social Security number) **is your identification number.**

Line 2: Enrollee Name is same as subscriber. All communications are addressed to this name.

Line 3: Group Number tells BCBSM you are a BCBSM group subscriber.

Coverage Codes identify the kind of coverage you have:

BC represents hospital and other facility coverage
BS represents medical-surgical coverage
D represents dental coverage
V represents vision coverage
H represents hearing coverage
DRAMS logo represents prescription drug coverage

Your BCBSM ID card is issued once you enroll for coverage. It lets you obtain services covered under your health care plan. Only the subscriber's name appears on your ID card(s). However, the card is for use by all covered members covered on your contract.

Here are some tips about your ID card:

- Sign the signature strip immediately to help prevent fraudulent use.
- Carry your card with you at all times to help avoid delays when you need medical attention.
- If you, or anyone in your family, need a card, please call the Fund Office.
- Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.
- Call the Fund Office if your card is lost or stolen. You can still receive services by giving the provider your contract number to verify your coverage.

Customer Service

As a Blues member you are very important. You should call the customer service number in Section 1 anytime you have a question about your health care plan.

To help BCBSM service you better, here are some important tips to remember:

- Have your contract number ready
- If you are questioning a service, please provide:
  - Patient and provider's name
  - Date the patient was treated
  - Type of service, such as an office visit
  - Charge for each service
- When corresponding with BCBSM, please make sure your contract number is on each page and you should keep a copy for your records.
- When visiting BCBSM Customer Service offices, please take a copy of any bills, forms or other materials related to your inquiry.

Preventing Fraud

BCBSM tries to prevent fraudulent use of your ID card. Only you and eligible members listed on your application card are covered for services.

A provider of medical services may ask for identification other than the BCBSM ID card. Checking the identification of the cardholder is one way of preventing unauthorized use of your card.

If you think someone is using your card illegally, or that you are being billed for services you did not receive, call the BCBSM Anti-Fraud Hotline:

- In Michigan: 1-800-482-3787
- Outside Michigan: 1-313-225-8100. your call will be transferred to the BCBSM Anti-Fraud Unit.

All calls are toll-free in Michigan. However, there is a charge outside Michigan. Your call is strictly confidential.

You may also write:

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

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SECTION 4. DEPENDENT ELIGIBILITY

DEPENDENT COVERAGE

Blue Cross Blue Shield of Michigan provides full coverage for your family dependents when they are properly enrolled. Eligible dependents are:

- Your spouse
- Unmarried children until the end of the year in which they reach age 19. They may remain covered to any age if they are "totally and permanently disabled by either a physical or mental condition prior to age 19".

Eligible Children Include:

- Your children by birth
- Your children by legal adoption
- Your children by legal guardianship (while they are in your custody and dependent on you)
- Your spouse's children

Dependent Continuation Coverage

Dependents who are between 19 and 25 may continue coverage under your contract if they meet all the following requirements:

- Be unmarried and between 19 and 25.
- Be related to you by blood, marriage, or legal adoption.
- Be a member of your household unless they temporarily reside elsewhere, as in the case of college students.
- Be dependent on you for more than half of their support.
- Be a full-time student for at least five months of the year.

You must apply for Continuation Coverage before the end of the year in which the dependent turns 19. This coverage continues until the end of the year in which they turn 25, if they remain eligible. Coverage for these dependents will be exactly the same as yours. A self-payment is required to maintain eligibility.

Important: If you have a dependent who is no longer eligible for health coverage on your contract, BCBSM has many benefit options available to continue his or her coverage. Call the customer service number in Section 2 for more information.

Sponsored Dependents

Dependents who are over 19 and not eligible for Continuation Coverage may be eligible for coverage as a "sponsored dependent" if they meet **all** the following requirements:

- Be related to you by blood, marriage, or legal adoption
- Be members of your household
- Be dependent on you for more than half of their support

You are responsible for paying the cost of coverage for each sponsored dependent.

Sponsored dependents are not eligible for dental, vision, hearing or Master Medical coverage, if these are part of your BCBSM coverage.

To Add a Dependent to Your Contract

When you become a BCBSM subscriber, your eligible dependent family members may be added to your contract.

To add a dependent to your contract, notify your Fund Office and fill out an Enrollment/Change of Status form. Please notify the Fund Office within 30 days* of the date any change occurs (date of event) so your records can be adjusted. The chart below shows the coverage effective date when the Fund Office is notified within 30 days.

To Add	Effective Date of Coverage
Spouse	Date of marriage.
Newborn	Date of birth.
Adopted Child	Date of placement. Placement occurs when the member becomes legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is require.
Principally supported child	Nine months from the date support began. You may request to add the child after providing six months of support.
Child under legal guardianship	Date legal guardianship is granted or when the date of petition for legal guardianship and residency is established.
Child between 19 and 25	Can be added, but there may be additional cost to you, if eligible. You must notify the Fund Office within 30 days of the end of the year in which your child turns 19.

**If the Fund Office is notified more than 30 days after the date of the event, the change to your contract could be delayed.*

To Remove a Dependent From Your Contract

When you (the subscriber) need to remove a dependent from your contract, notify your Fund Office and fill out an Enrollment/Change of Status form.**

Be sure to include your group and contract numbers, the dependent's social security number, the date you would like the dependent removed, and the reason for removing the dependent.

See the chart below for information about removing dependents. Remember, if a dependent child is no longer eligible, you must notify your Fund Office promptly.

To Remove	Reason for Removal	Effective Date of Removal
Spouse	Divorce or legal separation	Date of the divorce or legal separation
Child	Marriage Reaches 19 or 25 and is no longer eligible for coverage	Date of marriage The end of the year in which the child turns 19 or 25
Any dependent	Death	First day following the date of death

***If the Fund Office is notified more than 30 days after the date of the event, the change to your contract will be delayed which may cause errors when your claims are processed. Please remember to report any membership changes to your Fund Office promptly so these changes can be reflected on your records. If you fail to give timely notice of a divorce, you may be liable for any payments made by BCBSM on behalf of your ex-spouse for medical services that have been provided subsequent to the date of your divorce.*

To Change Your Address

If you change your address, or if your address is incorrect in BCBSM's records, please notify your Local Union of your address change and fill out an Enrollment/Change of Status form promptly and forward it to the Fund Office. This will ensure that you will continue to receive any notices BCBSM sends to you. Remember to include your group and contract numbers whenever you contact BCBSM, the Fund Office, or your Local Union.

CONTINUING COVERAGE ON YOUR OWN

Coverage for you and your dependents ends when you are no longer eligible for coverage through the Fund. However, you may continue your coverage under one of these options:

1. Through the Fund's Self-Payment Program.

2. Continue **temporary** coverage through the Fund under a federal legislative act known as **COBRA** (Consolidated Omnibus Budget Reconciliation Act), **or**

3. Convert to individual coverage, called **Group Conversion** through BCBSM. An explanation of both options has been provided; however, you will need to call the Fund Office to clarify eligibility dates and to select the type of coverage best for you.

CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any pre-existing condition exclusion periods that might otherwise apply when changing coverage. When your coverage through the Fund ends, you will receive a certificate coverage. You also may request a certificate for health coverage for periods of coverage on and after July 1, 1996, within 24 months of loss of coverage.

BLUE CROSS BLUE SHIELD GROUP CONVERSION COVERAGE

BCBSM has individual coverage, called Group Conversion. Group Conversion coverage is available to you either:

- As an alternative to COBRA when you first become eligible for COBRA **or**

- At the end of your COBRA eligibility period **if** you made all required payments during that period.

Your benefits may change under Group Conversion coverage, and the coverage will be limited to your immediate family, but there will be no interruption of coverage provided you pay the initial and subsequent bills. You must be a Michigan resident for at least six months out of each year to be eligible for this type of coverage.

To ensure continuous coverage, you must submit a written request for Group Conversion coverage to BCBSM within 30 days from the date you are no longer eligible for group coverage **or** within six months before the COBRA coverage ends. For additional information on how to apply for this coverage, contact a BCBSM customer service representative.

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SECTION 5. CHOOSING A PARTICIPATING PROVIDER

WHAT YOU NEED TO KNOW

This section provides information to help you understand and use your BCBSM coverage. You will find information about the following:

- What is a participating provider
- How to locate participating providers
- What is a nonparticipating provider
- BlueCard program
- Care out of the country

Your health care plan provides you with the highest level of benefits and the lowest of out-of-pocket costs if any when you choose participating providers. You also have the freedom to receive care from a nonparticipating provider, but with higher out-of-pocket costs.

PARTICIPATING PROVIDERS

Participating providers include physicians and other licensed professional providers, and hospitals and other approved facilities that have signed agreements with BCBSM to accept the BCBSM approved amount for covered services as payment in full, and they will not balance-bill you. Participating providers usually display the BCBSM emblem in their offices. When you use a participating provider they will bill BCBSM directly. This means you are not required to complete paper work or save and submit receipts.

Locating Participating Providers

To locate a Blue participating provider in Michigan, you can call the customer service number 1-800-411-1141 or visit the BCBSM Internet Web site at http://www.bcbsm.com.

Here's what you need to do when you need medical care:

- Choose a provider from the BCBSM Managed Traditional Participating Provider Network, and

- Make your appointment directly with that provider.

Tip: It's a good idea to confirm that the doctor participates with BCBSM at the time you schedule your appointment or visit.

You do not have to choose just one provider for your care and you do not have to notify BCBSM if you choose to change providers.

NONPARTICIPATING PROVIDERS

Nonparticipating providers have not signed agreements with BCBSM. If you receive services from a nonparticipating provider, you are usually required to pay providers directly and then submit a claim to BCBSM for payment. Remember the BCBSM approved amount may be less than the amount your provider charged you.

BCBSM does not pay for services at nonparticipating outpatient physical therapy, outpatient mental health, substance abuse facilities or home health agencies.

BCBSM coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency. The following explains your coverage when provided by a nonparticipating hospital.

Emergency Services at a Nonparticipating Hospital

Benefits are payable at the BCBSM approved amount for emergency services provided by an **accredited nonparticipating hospital** located outside Michigan in an area not served by another Blue Cross Blue Shield Plan **or** a facility that participates with another Blue Cross Blue Shield Plan, regardless of the facility's location.

Emergency Services at a Michigan Nonparticipating Hospital

Benefits are payable for a portion of the charges for emergency services charged by a Michigan accredited nonparticipating hospital if the hospital is located in Michigan **and** not participating with another Blue Cross Blue Shield Plan.

When you receive emergency services at a Michigan nonparticipating hospital, payment is limited to:

- $70 per day for inpatient services in an accredited general acute-care facility

- $15 per day in an accredited specialty hospital such as a psychiatric hospital, and

- $25 per condition for covered **outpatient** emergency services. You must pay the balance.

BLUECARD PROGRAM

When you need medical care outside of Michigan, just call the toll-free number below and you will be directed to the nearest Blue participating provider. BlueCard participating providers will bill their local Blue Plan for any covered services you receive and will accept the approved amount or negotiated price (see Glossary) as payment in full. You are responsible only for applicable deductible and copayments, and for services not covered by your plan.

To take advantage of your Blue Card program, just follow these three steps:

1. Call 1-800-810-BLUE (2853) any day of the week. You will be given the name of the nearest participating physician or hospital.

   Note: If you need emergency medical care, please seek care immediately from the nearest hospital or physician.

2. Show your BCBSM ID card and remind the provider you are covered under the BlueCard Program and to include the alpha prefix on all claims.

3. Pay applicable deductibles and copayments required by your plan.

Important: You may need to submit itemized receipts directly to BCBSM if you receive services from a nonparticipating provider. Also BlueCard does not include prescription drugs, dental, vision and hearing services.

CARE OUT OF THE COUNTRY

Your coverage applies no matter where you are only if:

- The hospital is accredited
- The physician is licensed

Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, please inform BCBSM if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. BCBSM will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles or copayments that may apply.

SECTION 6. HOW YOUR COMPREHENSIVE MAJOR MEDICAL (CMM) HEALTH CARE PLAN WORKS

This section provides information to help you understand how your health care plan works.

BENEFIT PERIOD

Payment of your CMM benefits, including deductibles and annual dollar maximums, are based on a calendar year, beginning January 1 and ending December 31. Your first benefit period may be shorter, depending on your effective date and when you become eligible for coverage.

DOLLAR MAXIMUMS

Your CMM covered services are limited to a lifetime dollar maximum of $5 million per member.

PAYMENT OF BENEFITS

Under your health plan, covered services and supplies are called "benefits". The payment allowed for benefits is called the "approved amount". Blue Cross Blue Shield of Michigan determines the approved amount and it is the lesser of the billed charge or maximum payment amount allowed for covered services. Applicable deductibles and copayments are deducted from the BCBSM approved amount.

YOUR OUT-OF-POCKET COSTS

For most covered services, you are required to pay a portion of the approved amount through deductibles and copayments.

Your Deductible

Your CMM coverage requires a **$100** per member or **$200** per family deductible before benefits are payable for covered services. This deductible is required each calendar year.

Note: When one individual has met the deductible, benefits are payable for covered services for that individual. Services for the remaining family members will be paid when the full family deductible has been met.

Any amounts incurred and applied toward your deductible during October, November or December may be carried over to help meet your deductible for the next year.

Your Percent Copayments

After you have met your deductible, you are responsible for the following copayments:

- 10 percent for general services
- 50 percent for mental health care
- 50 percent for substance abuse care
- 50 percent for private duty nursing

Your Copayment Maximum

After you have paid $1,000 per family in copayments for general services, you do not need to pay any further copayments for the rest of that year. However, you are still required to pay copayments for mental health care, substance abuse care and private duty nursing.

The following **cannot** be used to meet your copayment maximum:

- Deductibles
- Mental health care, substance abuse care and private duty nursing copayments
- Fixed dollar copayments, if applicable
- Charges for non-covered services
- Charges in excess of the BCBSM approved amount
- Deductibles or copayments required under other Blue Cross Blue Shield of Michigan coverage

SECTION 7. COMPREHENSIVE MAJOR MEDICAL (CMM) HOSPITAL COVERAGE

This section explains the benefits available to you under the Comprehensive Major Medical (CMM) health care plan. Please check each section of this booklet carefully for a complete explanation of your benefits.

Note: Unless otherwise indicated, all services described in this section are subject to the deductible and copayments listed in the previous section.

MEDICAL NECESSITY

A service must be medically necessary in order to be payable by your health care coverage.

Medical necessity for the payment of **hospital services** requires that all of the following conditions be met:

- The covered service is for the treatment, diagnosis, or symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
    - Appropriate means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
    - For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross Blue Shield of Michigan.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment Programs.

Important: In some cases, you may be required to pay for covered services even when they are medically necessary. These limited situations are:

- When you don't inform the hospital that you are a Blue Cross Blue Shield member either at the time of admission or within 30 days after you have been discharged.

- When you fail to provide the hospital with information that identifies your coverage.

PAIN MANAGEMENT

Blue Cross Blue Shield of Michigan considers pain management an integral part of a complete disease treatment plan. BCBSM provides coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to contract limitations.

HOSPITAL BENEFITS – INPATIENT CARE

Your coverage includes the following hospital services.

Room and Board

Your benefits include the cost of a semi-private room; the use of special units such as intensive burn, or cardiac care; meals and special diets; and general nursing care. However, the cost of a private room is not covered. If you request a private room, your coverage will pay the cost of a semi-private room and you will be required to pay the difference.

General Medical Care Days

You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions.

The following types of admissions also are considered general medical care:

- **Maternity and nursery care** – includes delivery room costs and routine nursery care for a newborn during an eligible mother's hospital stay. After the hospital stay, the

newborn is covered as a dependent child. You must notify the Fund Office to add the child to your coverage within 30 days of birth.

Note: Under federal law, BCBSM generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending physician may, after consulting with the mother, discharge the mother or the newborn earlier. BCBSM also may not require a provider to obtain authorization for prescribing a length of stay not in excess of the 48/96-hour minimum.

- **Cosmetic surgery** – includes correction of birth defects, conditions resulting from accidental injuries or traumatic scars, and the correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.

- **Dental surgery** – includes removal of impacted teeth or multiple extractions only when a concurrent hazardous medical condition, such as heart condition, exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

Mental Health Care and Substance Abuse Treatment Days

You have 60 days for inpatient mental health care up to a lifetime maximum of 120 days. You have unlimited days for substance abuse treatment up to the lifetime dollar maximum. Benefits are payable when services are provided in BCBSM-approved hospitals and in approved day- and night-care centers.

A mental health or substance abuse treatment admission can include individual and group therapy sessions and family counseling when provided through an approved facility.

A fully licensed psychologist with hospital privileges can be directly reimbursed for the following inpatient services:

- Individual psychotherapeutic treatments.

- Family counseling for members of a patient's family.

- Group psychotherapeutic treatment.

- Inpatient consultations when your physician requires assistance of a consulting psychologist in diagnosing or treating your mental health condition.

Important: Inpatient mental health care and substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. To determine that the criteria will be met, your physician should call the BCBSM Mental Health Pre-certification Unit at 1-800-762-2382 for guidance.

Hospital Services and Supplies

The following services and supplies are covered when they are needed during a hospital admission:

- **Anesthesia** – includes administration, cost of equipment, supplies, and the services of a hospital anesthesiologist when billed as a hospital service.

- **Blood services** – includes whole blood, blood derivatives, blood plasma, and supplies used for administering the services.

- **Laboratory and pathology tests** – includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service.

- **Drugs** – includes medicines prescribed and given during a hospital admission.

- **Durable medical equipment** – includes items such as oxygen tents, wheelchairs, and other hospital equipment used during the hospital stay.

- **Medical and surgical supplies** – includes gauze, cotton, and solutions used during the hospital admission.

- **Prosthetic and orthotic appliances** – includes items that are surgically implanted in the body, such as heart valves.

- **Special treatment rooms** – includes operating, delivery, and recovery rooms.

Your coverage includes the following diagnostic and radiology services:

- **CAT and MRI scans** – covers scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBSM.

- **Diagnostic tests** – includes EKGs, EMGs, EEGs, thyroid function tests, and nerve conduction studies required in the diagnosis of an illness or injury.

- **Therapeutic radiology** – includes radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

- **Diagnostic radiology** – includes ultrasound and X-rays required for the diagnosis of an illness or injury.

HOSPITAL BENEFITS – OUTPATIENT CARE

The following services are covered when performed in the outpatient department of a participating hospital or, where noted, in a freestanding facility approved by BCBSM.

Pre-Admission Testing

Testing must be performed in the outpatient department of a hospital within seven days before a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.

Physical, Occupational, and Speech Therapy

Your physical, occupational, and speech therapy services (see Glossary for definitions) are payable when provided in:

- The outpatient department of participating hospitals

- Outpatient participating physical therapy facilities

In addition, physical therapy services are payable when provided in the physician's office or the office of an independent licensed physical therapist.

Important: Payment for therapy is based on the diagnosis and the location.

Your therapy must:

- Be prescribed by the patient's attending physician
- Require the assistance and supervision of the appropriate licensed therapist
- Be designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury
- Be given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered therapy are:

- Physical therapy prescribed to restore the musculoskeletal functioning of legs
- Physical therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints

Your coverage does **not** pay for:

- Long-standing chronic conditions such as arthritis
- Health club membership or spa membership
- Developmental conditions or learning disabilities
- Congenital or inherited speech abnormalities
- Inpatient hospital admissions principally for speech or language therapy

EMERGENCY MEDICAL CARE

Your coverage provides the following benefits:

Emergency Medical Care in the Emergency Room

Your benefits include the initial exam and treatment of accidental injuries or conditions determined by BCBSM to be medical emergencies (see Glossary for definitions). Please see Section 5 for important information regarding payment of emergency services at nonparticipating hospitals.

Note: Routine care for minor medical problems such as headaches, colds, slight fever and back pain is not considered emergency care. Also, follow-up care is not considered emergency care.

Professional Ambulance Services

Ambulance services are covered to transport a patient up to 25 miles unless the destination is the nearest medical facility capable of treating the patient's condition. The service must be medically necessary, prescribed by a physician (when used for transferring a patient), and provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation. Air ambulance is also covered when no other means or transport is available or the patient's condition requires air transport rather than ground ambulance. For air ambulance, the provider must be licensed as an air ambulance service and is not a commercial air carrier.

Your coverage does **not** pay for:

- Transportation for the convenience of the patient or the patient's family, or for the preference of the physician.

- Ambulance services provided by a fire department, rescue squad, or other carrier whose fee is a voluntary donation.

OUTPATIENT MENTAL HEALTH CARE

Your coverage includes psychological testing, individual and group therapy sessions, and family counseling. These services must be provided through an approved facility or by a physician or fully licensed psychologist.

Benefits are payable for 50 visits per person, per calendar year up to a lifetime maximum of 120 visits.

OUTPATIENT SUBSTANCE ABUSE TREATMENT

Treatment is covered when provided in approved outpatient substance abuse treatment facilities. These benefits are payable up to the annual minimum dollar amount designated by state law.

Note: Since this amount is adjusted annually, you should call the customer service number in Section 2 for the current benefit amount.

CHEMOTHERAPY

Treatment is payable in a hospital, in the outpatient department of a hospital, or in a physician's office. Your benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy, and provided as part of a chemotherapy program.

HEMODIALYSIS

Hemodialysis services are covered to treat acute kidney failure and end stage renal disease (ESRD). You can receive treatment in the outpatient department of a hospital or in a licensed facility. You can also receive dialysis services in the home if the owner of the patient's home gives the hospital prior written permission to install the equipment.

Your physician must arrange for home hemodialysis and all services must be billed by a participating hospital that has an approved hemodialysis program. Benefits include cost of the equipment, installation, training and necessary hemodialysis supplies.

Important: Dialysis services for the treatment of ESRD are coordinated with Medicare. It is important that individuals with ESRD apply for Medicare coverage regardless of age. Blue Cross Blue Shield is the primary payer for up to 33 months, which includes the three-month waiting period, if the member is under 65 and is eligible for Medicare solely because of ESRD.

ALTERNATIVES TO HOSPITAL CARE

Your coverage provides the following benefits:

Home Hemophilia Program

Your benefits include all medications and medical supplies needed for in-home treatment of hemophilia, including syringes, needless and the antihemophilic factor. You can receive treatment in the outpatient department of a hospital or a licensed facility. You can also receive dialysis services in the home, if the owner of the patient's home gives the hospital prior written permission to install the equipment. Your benefits also include training the patient or a family member on how to inject the antihemophilic factor, when the training is provided through an approved facility.

Home Health Care

To receive benefits under the ~~home~~ Home Health Care program, a physician who certifies that the patient is confined to the home due to illness, must prescribe and submit a detailed treatment plan to the home health care agency.

Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

- Part-time health aide services if the patient is receiving skilled nursing care or physical or speech therapy and the health care agency has identified a need for the patient to have these services.

- Social services and nutritional guidance when requested by the patient's physician.

- Physical, speech, and occupational therapy are payable when provided for rehabilitation.

- Nursing care when supervised by a registered nurse employed by the home health care agency.

Important: The Fund does not pay for general housekeeping services, for transportation to or from a hospital or other facility, for elastic stockings, sheepskin or comfort items such as lotion, mouthwash, body powder, etc., for physician services, and for custodial or nonskilled care.

Individual Case Management Program (ICMP)

Individual Case Management is a voluntary program through which care is provided outside a hospital setting. The program is designed to assist an individual whose cost of medical care is very high or whose care would exhaust available benefits.

Patients are referred by a hospital, physician or a family member. A case management analyst will evaluate the patient for participation in ICMP, and if the patient is accepted as a candidate for ICMP, the analyst works with the patient's family and physician to develop a personal treatment plan, called the Alternative Benefit Plan. The plan can include services not normally included in your coverage. The analyst also identifies all payable services and payment arrangements related to the plan.

Note: Whenever possible, BCBSM will identify more than one provider for services recommended in the plan. The patient and family then have the option to select the provider.

After reviewing the Alternative Benefit Plan documents, the patient and family can decide whether or not to accept the plan. Participation is entirely voluntary.

Once the treatment plan is implemented, participation can be canceled if:

- The patient's condition no longer requires the extra benefits documented in the Alternative Benefit Plan.
- The total amount paid under the Alternative Benefit Plan exceeds the amount that would be payable under the patient's regular hospital coverage.

If you have questions about the Individual Case Management Program, you may call a case management representative at 1-800-845-5982.

Hospice Care

A hospice is an agency that is primarily involved in providing care to terminally ill individuals and can be used as an alternative to hospitalization. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

The patient or his/her representative may apply for hospice care benefits with a referral by the patient's attending physician. Election of Hospice benefits must be in writing to the hospice agency and all hospice services must be arranged through an approved hospice provider.

- **Electing Hospice Benefits** – When the patient elects to enter into the program, the hospice benefits will replace the patient's CMM benefits for conditions related to the terminal illness. The hospice benefits will be more specific to the patient's needs and may include alternative services that provide more appropriate care. However, medical services unrelated to the terminal illness are covered according to your CMM coverage. The patient may cancel, in writing, all hospice benefits at any time. When services are canceled, the patient's regular coverage resumes.

- **Levels of Care** – The hospice program provides four levels of care:

  - **Routine home care** that consists of services provided to patients who are living at home and are not receiving continuous home care (see next item). Benefits include counseling, home health care, and physical therapy. Such care must not exceed eight hours per day.

  - **Continuous home care** that consists of nursing care services provided to patients during crisis periods to enable them to stay at home. Such care is covered up to 24 hours per day during periods of crisis.

  - **Inpatient respite care** that consists of short-term inpatient services to allow the home care provider short periods of relief. Such care must be provided in an approved facility on a non-routine or occasional

basis and in increments of five days or less in any 30-day period.

- **General inpatient care** that consists of services for pain control and acute and/or chronic symptom management that cannot be provided in other less intensive settings.

- **Hospice Services** – The following benefits are payable under the hospice program up to the dollar maximum amount that is reviewed and adjusted annually. Please call the customer service number in Section 1 for the current maximum amount.

  - **Nursing care** when provided by or under the supervision of a registered nurse.

  - **Medical social services** by a qualified social worker, provided under the supervision of a physician.

  - **Counseling services** for the patient and caregivers, when care is provided in the home and for family bereavement after the patient's death.

  - **Medical appliances and supplies** to provide comfort to the patient and when approved by BCBSM.

  - **Durable medical equipment** when furnished by the hospice program for the patient's home.

  - **Physician, speech and occupational therapy** when provided to control symptoms and maintain the patient's daily activities and basic functional skills.

  - **Bereavement counseling** for the family after the patient's death.

Important: There is a separate dollar maximum for services provided by a physician who is not part of the hospice team. Please call the customer service number in Section 1 for information about the current dollar maximum.

HUMAN ORGAN TRANSPLANTS

The following types of human organ transplants are covered when received at a participating hospital or, where noted, in a BCBSM-approved transplant facility, and designated transplant facility.

Organ and Tissue Transplants

Benefits are payable for services performed to obtain, test, store and transplant the following human tissues and organs:

- Cornea
- Kidney
- Skin
- Bone Marrow (described below)

The fund will pay covered services for donors if the donor does not have transplant benefits under any health care plan.

Bone Marrow Transplants

Benefits for allogeneic bone marrow transplants are payable only when the bone marrow of another person is transplanted into the patient to treat the following conditions and is not considered experimental or investigational.

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

Allogeneic bone marrow transplants are payable when the donor is an immediate relative (mother, father, sister or brother) and has four of the six important HLA genetic markers as the patient. Donors outside of the immediate family must have five of the six important HLA genetic markers as the patient.

Reminder: HLA (human leukocyte antigens) genetic markers are specific chemical groupings of many body cells, including white blood cells used to detect the constitutional similarity of one person to another.

Your coverage also includes transplants of the patient's own bone marrow (autologous) and/or transplanting the patient's own peripheral blood stem cells when used to rescue a patient after receiving high doses of chemotherapy. The transplant cannot be considered experimental or investigational.

Only the following conditions are covered:

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

Payable benefits for bone marrow transplants include:

- High-dose chemotherapy and/or total body radiation

- Blood tests on immediate relatives for evaluation as donors (if tests are not covered by the potential donor's health plan)

- Harvesting the marrow and/or peripheral blood stem cells if the donor meets specific genetic marker requirements for allogeneic bone marrow transplants; harvesting and storing the marrow and/or peripheral blood stem cells for a

transplant intended to be performed within one year for autologous bone marrow transplants

- Search of the National Bone Marrow Donor Program Registry for a donor (a search will begin only when the need for a donor is established)

- Infusion of colony simulating growth factors

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

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

Reminder: Benefits are also payable for similar services related to or for high-dose chemotherapy, total body radiation, allogeneic or autologous bone marrow and/or peripheral blood stem cell transplants to treat conditions other than those listed above if the services are not otherwise excluded from coverage as experimental or investigational. This benefit does not limit or preclude coverage as antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Your coverage does **not** pay for:

- Any services related to or for allogeneic bone marrow transplants and/or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements.

- Purging of and/or positive stem cell selection of bone marrow stem cells, or peripheral blood stem cells.

- Harvesting and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplant within one year.

- Health care services provided by persons who are not legally qualified or licensed to provide such services.

- Services that are not medically necessary (see Glossary for a definition of medical necessity).

- Any facility, physician or associated services related to any of the above exclusions.

Specified Oncology Clinical Trials

Covers antineoplastic drugs to treat stages II and III breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

In order for services to be payable as eligible benefits:

- The inpatient admission and length of stay must be medically necessary and preapproved (no retroactive approvals will be granted);

- The services must be performed at a National Cancer Institute (NCI)-designated cancer center or an affiliate of an NCI-designated center;

- The treatment plan, also called protocol, must meet the guidelines of the February 19, 1993, American Society of Clinical Oncology (ASCO) statement for clinical trials; and

- The patient must be an eligible BCBSM member with hospital/medical/surgical coverage.

Note: If the above requirements are not met, you will be responsible for all charges.

Covered Services

Covered services are payable when directly related to a bone marrow transplant, peripheral blood stem cell transplant, high-dose chemotherapy or total body radiation.

When pre-approved by BCBSM, the following services are covered:

- Allogeneic transplants (including syngeneic transplants when the donor is the identical twin of the patient)

    - Blood tests to evaluate donors (if not covered by the potential donor's health plan).

    - Search of the National Bone Marrow Donor Program Registry for a donor (a search will begin only when the need for a donor is established). The registry's bill must be submitted to BCBSM by the designated cancer center.

    - Infusion of colony stimulating growth factors.

    - Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor's health plan).

    - Purging of, or positive stem cell selection of, bone marrow or peripheral blood stem cells.

    - High-dose chemotherapy and/or total body radiation.

    - Infusion of bone marrow and/or peripheral blood stem cells.

- Autologous transplants

    - Infusion of colony stimulating growth factors.

    - Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor's health plan).

    - Purging of, or positive stem cell selection of, bone marrow or peripheral blood stem cells.

    - High-dose chemotherapy and/or total body radiation.

- Infusion of bone marrow and/or peripheral blood stem cells.

- Pre-approved hospitalization in an intensive care unit, special care unit, or private room.

- Up to a total of $5,000 for travel, meals, and lodging expenses directly related to pre-approved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins on the date of approval and ends 180 days after the transplant. The Fund will pay the expenses of an adult patient and one companion (or two companions if the patient is under age 18). Within the $5,000, the following amounts apply to the combined expenses of the patient and eligible companion(s):

  - Up to $60 per day for travel
  - Up to $50 per day for lodging
  - Up to $40 per day for meals

Your coverage does **not** pay for:

Services performed at a center that is not a National Cancer Center (NCI)-designated center or an affiliate of a NCI-designated center.

A hospital admission, a length of stay at a hospital, or any service that has not been pre-approved.

Harvesting (including phereses) and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplantation within one year.

Any other services related to any of the above exclusions.

Items or services, such as investigational drugs, non-health care services and/or research management (such as administrative costs) that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company).

Services rendered as part of a protocol that does not meet the February 19, 1993 ASCO statement for clinical trials.

Items that are not considered directly related to travel, meals, and lodging expenses. They include, but are not limited to, dry cleaning/clothing/laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), care maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationary/stamps, household products, household utilities including cell phone charges, maid, babysitter/day care services.

Specified Human Organ Transplants

Hospital care for specified human organ transplants performed during the transplant benefit period is covered in full when the transplant is received at a BCBSM designated transplant facility (see Glossary for a definition of a designated facility).

- Benefits apply only to transplants of the:
  - Liver
  - Partial liver (a portion of the liver taken from a cadaver or living donor)
  - Heart
  - Lung(s)
  - Lobar lung (transplantation of a portion of a lung from a cadaver or living donor)
  - Heart-lungs
  - Pancreas
  - Simultaneous pancreas-kidney
  - Small intestine (small bowel)
  - Combined small intestine-liver
- All payable human organ transplant services, except anti-rejection drugs, must be provided during the benefit period that begins five days before the transplant surgery and ends one year after the surgery.
- The transplant facility or your physician must request authorization from BCBSM before surgery. Authorization for the transplant surgery will be sent to you and the transplant facility or your physician (whoever requests the pre-authorization).

Note: Call the BCBSM Human Organ Transplant Program at 1-800-242-3504 if you have questions about specified organ transplant benefits.

When pre-approved and directly related to the transplant benefits are payable for the following services. **Benefits are limited to a $1 million lifetime maximum for each type of human organ transplant**.

- Facility and professional services.

- Anti-rejection drugs and other transplant-related prescription drugs, as needed. Payment will be based on the amount BCBSM determines to be reasonable and necessary. The BCBSM payment for the drugs is limited only by the $1 million lifetime maximum.

- Medically necessary services needed to treat a condition rising out of the organ transplant surgery if the condition occurs during the benefit period, and is a direct result of the organ transplant surgery. BCBSM will pay for any medically necessary service needed to treat a condition as a result of the organ transplant surgery, if it is a benefit under any of Blue Cross Blue Shield certificates.

- Up to $10,000 for travel, meals and lodging directly related to pre-approved services.

- The cost of transportation to and from the designated transplant facility for an adult patient and one companion eligible to accompany the patient (or two companions if the patient is under age 18 or if the transplant involves a living related donor). Within the $10,000, BCBSM will pay the reasonable and necessary costs of meals for the patient and eligible companion(s), up to a combined maximum of $40 per day, and the costs of lodging for the eligible companion(s).

- The cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ, transportation of the organ and payment for covered services for a donor if the donor does not have transplant services under any health care plan. The total payment for all services combined for each transplant type will not be more than the $1 million lifetime maximum.

Your specified transplant coverage does **not** cover:

- Non-covered services.
- Living donor transplants other than liver and lobar lung transplants.
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin).
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval.
- Transplant procedures and related services that are not pre-approved.
- Transplant surgery that is not performed in a designated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial pre-approved transplant surgery.
- Any expenses incurred for transportation, meals and lodging after the initial transplant surgery and hospitalization.
- Items not considered directly related to travel, meals and lodging expenses. They include, but are not limited to, dry cleaning/clothing/laundry services, kennel fees, entertainment (cable, movie rentals, television, books, magazines), care maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationary/stamps, household products, household utilities including cell phone charges, maid, babysitter/day care services.
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage.
- Experimental transplant procedures.

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SECTION 8. PHYSICIAN BENEFITS

CMM PHYSICIAN COVERAGE

Your coverage provides the following benefits for physician care:

Medical Necessity

Medical necessity for **physician services** is determined by physicians acting for their respective provider types and/or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

- The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnostic.

- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition, or illness. It is not mainly for the convenience of the members or physicians.

- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

- In the absence of established criteria, medical necessity will be determined by physician or professional review according to generally accepted standards and practices.

- The Blue Cross Blue Shield of Michigan determination of medical necessity for payment purposes is based on standards of practice established by physicians.

Preventive Services

Your coverage pays for the following preventive services:

- **Pap smear screening** – covers laboratory services for one routine pap smear every 12 months. More frequent pap smears are covered for the following conditions:

- Previous surgery for vaginal, cervical or uterine malignancy
- Presence of a suspected lesion in the vaginal, cervical or uterine areas
- Post-surgery

- **Prescribed contraceptive devices** – covers physician-prescribed contraceptive devices such as diaphragms, and IUDs, and their insertion.

Office Visits

The exam, diagnosis, and treatment of illness or injury by a physician is payable when you are seen in the physician's office, outpatient clinic, or outpatient department of a hospital. Injections are covered with an eligible diagnosis.

Allergy Services

Your benefits provide for allergy testing, survey, testing and therapeutic injections when performed by or under the supervision of a physician. Benefits are not payable for fungal or bacterial skin tests, such as those given for tuberculosis or diphtheria, self-administered or over-the-counter medications, psychological testing, evaluation or therapy for allergies, environmental studies, evaluation, or control.

Chiropractic Services

Your benefits include the following chiropractic services:

- **New patient office visits** – covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.
- **Office visits** – covers one every calendar year for established patients.
- **Chiropractic traction** – number of payable visits is determined by your physical therapy benefit.

- **Chiropractic manipulation** – limited to one per day, up to 38 medically necessary visits per calendar year.

Maternity Care

You have coverage for obstetrical services including delivery and pre- and post-natal care visits. The initial inpatient examination of the newborn is a benefit when performed by a physician other than the anesthesiologist or the delivering provider.

Note: Maternity care benefits also are payable when provided by a Certified Nurse Midwife. Delivery must be in a hospital or BCBSM-approved birthing center.

Surgery

Surgical benefits include the surgical fee and pre-and post-operative medical care given by the surgeon. Surgery is covered inpatient and outpatient, in the physician's office, and in approved ambulatory surgical facilities.

- **Multiple surgeries** (two or more surgical procedures performed by the same physician during one operative session) are subject to the following payment limitations:

  - When surgeries are through different incisions, BCBSM pays the approved amount for the more costly procedure and one half of the approved amount for the less costly procedures.

  - When surgeries are through the same incision they are considered related and BCBSM will pay the approved amount only for the more difficult procedure.

Note: Participating providers accept these approved amounts as payment in full, less any deductible and copayment. However, nonparticipating providers may bill you for the difference.

- **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars and for correction of

deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.

- **Breast reconstruction surgery** is covered for:
  - 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 lymphedemas.
- **Dental Surgery** is covered only for the removal of impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition exists, such as a heart condition. The inpatient admission for the dental surgery must be considered medically necessary ~~for~~ to safeguard the life of the patient.
- **Voluntary sterilization** for male and female patients is covered regardless of medical necessity.

Technical Surgical Assistance (TSA)

TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient, and in an approved ambulatory surgery facility.

Anesthesia

Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to certified registered nurse anesthetists. The Fund does not pay for local anesthetics.

Temporomandibular Joint Syndrome (TMJ) or Jaw-Joint Disorder

Benefits for TMJ or jaw-joint disorder are primarily limited to surgery directly to the jaw joint, X-rays (including MRIs), and arthrocentesis (injection procedures). However, some symptom-management services are covered, such as office visits, reversible appliance therapy, physical medicine (diathermy, hot and cold applications), and medications.

Other than the exceptions noted, benefits are not payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint, skull, and the muscles/nerves/tissue related to the jaw joint. These exclusions include (but are not limited to): crowns, inlays, caps, restorations, grinding, orthodontics, dentures, partial dentures or bridges.

If you are not sure that your prescribed treatment will be covered, ask your physician to contact BCBSM for approval before treatment begins.

Note: Irreversible treatment of the mouth, teeth, or jaw is intended to bring about permanent change to a person's bite or position of the jaws. It includes but is not limited to dentures, bridges, crowns, caps, inlays, restorations, grinding and orthodontics. Reversible treatment of the mouth and jaw is not intended to result in permanent alteration of the bite or position of the jaws; it is directed at managing the patient's symptoms.

Emergency Care

Your coverage provides payment of the approved amount for the initial exam and treatment of accidental injuries or conditions determined by BCBSM to be medical emergencies (see Glossary).

Note: Routine care for minor medical problems such as headaches, colds, slight fever or back pain is not considered emergency care.

Inpatient Medical Care

Medical supervision by the attending physician is payable while you are in the hospital or in a skilled nursing facility for general medical conditions that are not related to surgery or maternity care.

Inpatient and Outpatient Consultations

Medical consultations are payable when your physician requires assistance in diagnosing or treating a condition or because special skill or knowledge of the consulting physician is required.

Diagnostic and Radiation Services

Physician services are payable to diagnose disease, illness, pregnancy or injury through:

- **Diagnostic radiology** – includes X-rays, ultrasound, radioactive isotopes, and Magnetic Resonance Imaging (MRI) and CAT scans of the head and body when performed for an eligible diagnosis.

- **Laboratory and pathology tests**.

- **Diagnostic tests –** includes EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies.

- **Radiation therapy** – includes radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

- **Mammography screening** – covers one mammogram (breast X-ray) for a woman from the age of 35 to 40. At 40 and older, one mammogram per calendar year is covered. More frequent mammograms are covered if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.

OTHER COVERED SERVICES

Your coverage includes the following services:

Blood Services

Whole blood for transfusions is covered.

Oxygen and Other Therapeutic Gases

Oxygen and equipment to administer the oxygen are covered when prescribed by a physician and medically necessary.

Optical Services Following Cataract Surgery

Your benefits include the examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery. Cataract sunglasses are not covered.

Dental Services

Dental services and appliances required for the treatment of an accidental injury are covered. An external force must have caused the injury. Injuries resulting from biting or chewing are not covered.

Durable Medical Equipment (DME)

Benefits include rental or purchase (whichever is less expensive) and repair of durable medical equipment appropriate for home use and prescribed by a physician. The prescription must include a description of the equipment and a diagnosis. For rental equipment, a new prescription must be written when the current prescription expires.

Important: The Fund does not pay for exercise and hygienic equipment, for comfort and convenience items, for self-help devices, such as elevators, for deluxe equipment, such as motorized wheelchairs unless medically necessary and required so the patient can operate the equipment themselves, and for experimental or investigational equipment.

Medical Supplies

Your benefits provide for medical supplies and dressings for use in the home when prescribed by a physician for the treatment of a specific medical condition.

Prosthetic and Orthotic Appliances

Your benefits provide for prosthetic and orthotic appliances when they are prescribed by a physician and supplied by a licensed orthotist or prosthetist. Benefits cover temporary appliances, delivery, services and fitting charges. Adjustment or replacement of eligible appliances is payable only when required because of wear, growth or change in the patient's condition.

A device that replaces a limb or part of a limb must be furnished by a provider who is fully accredited by the American Board of Certification in Orthotics and Prosthetics, Inc. (ABC). Please call the customer service number in Section 1 for information about a provider's status.

Important: The Fund does not pay for non-rigid devices and supplies such as elastic stockings, garter belts, arch supports, corsets, shoe inserts and supportive appliances for the feet, hearing aids and hair prosthesis

such as wigs or hair implants. Corrective shoes are payable only when required to correct a physical defect and are attached to a leg brace.

Private Duty Nursing

Private duty nursing is covered when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis. Non-skilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered.

Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The attending physician must complete a Certification statement each month the patient is required to have private duty nursing care.

WHAT'S NOT COVERED

Your CMM Plan does **not** cover:

- Care and services available at no cost to you in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency.
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location.
- Custodial care, rest therapy, and care in nursing or rest home facilities.
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists.
- Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than as specified in this booklet.
- Hospital admissions that began before the effective date of coverage.
- Hospital admissions that begin after the coverage termination date.

- Medical services or supplies provided or furnished while coverage is not in effect (that is, before the effective date of coverage or after the coverage termination date).

- Health care services provided by persons who are not legally qualified or licensed to provide such services.

- Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions.

- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), basal metabolism tests, or electrocardiography.

- Items for the personal comfort or convenience of the patient.

- Psychiatric services after determination that the patient's condition will not respond to treatment.

- Psychological tests for vocational guidance or counseling.

- Premarital or pre-employment exams.

- Services and supplies that are not medically necessary according to accepted standards of medical practice.

- Services provided through a medical clinic or similar facility provided or maintained by an employer.

- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund.

- Care and services received under another certificate offered by Blue Cross Blue Shield of Michigan or another Blue Cross Blue Shield plan.

- Care and services payable by government-sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal law requires Medicare to be secondary.

- Cosmetic surgery and related services solely for improving appearance, except as specified in this booklet.
- Treatment of a condition caused by military action or war, declared or undeclared.
- Services, care, devices, or supplies considered experimental or investigative.
- Services for which a charge is not customarily made; services for which the patient is not obligated to pay or services without cost.
- Hearing exams and preparation, fitting, or procurement of hearing aids.
- Vision exams and eyeglasses or other corrective vision appliances except as specified in your coverage.
- Dental services and appliances except those specified in your coverage.
- Dialysis services after 33 months of ESRD treatment.
- Services that are not included in your plan coverage documents.
- Transportation and travel except as specified in this booklet.
- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan.
- Screening services, excluding mammograms, unless otherwise stated.
- Deductibles or copayments paid by the member under any other certificate.
- Physical therapy services performed by a chiropractor.
- Services, care, supplies, or devices not prescribed by a physician.
- Services provided during non-emergency medical transport.

SECTION 9. PRESCRIPTION DRUG COVERAGE

(Refer to Section 1 for eligibility.)

When medication is a necessary part of your total health care program, your health plan includes coverage for the following prescription drug services.

WHAT'S COVERED

You have coverage for:

- Federal legend and state-controlled drugs
- Compound medications containing at least one federal legend drug ingredient
- Injectable insulin
- Needles and syringes dispensed with insulin or chemotherapeutic drugs
- Contraceptive medications prescribed by a physician

Covered drugs may be dispensed in quantities of up to a 34-day supply, or, for certain maintenance drugs, 100-unit doses or 200-unit doses, whichever is greater.

Generic Equivalent Drugs

Pharmacists will automatically dispense the generic equivalent when appropriate, if there is a generic equivalent to a brand name drug. Generic equivalent drugs can be produced by more than one manufacturer and distributed under more than one name. The Food and Drug Administration requires that these generic drugs meet the same standards for active ingredients as brand name drugs. You pharmacist has a complete list of generic equivalent drugs included in your coverage.

Your pharmacist will dispense your prescription with a brand name drug under the following conditions:

- If your doctor prescribes a brand name medication to be "dispensed as written" when a generic alternative is

available. The doctor must write "Dispense as Written" or "DAW" on the prescription.

- If you request the brand name drug. You must pay the difference in cost between the brand name drug and the generic equivalent, in addition to your copayment.

Co-Branded Drugs

Co-branded drugs are chemically equivalent drugs sold under different brand names. They are designated "preferred" and "nonpreferred". When dispensing brand name drugs that are co-branded, your pharmacist must fill your prescription with the brand name drug identified as "preferred" by BCBSM.

When your prescription is filled with a co-branded drug, the Fund will pay the BCBSM approved amount for the preferred co-branded drug less your copayment. If your prescription is filled with a nonpreferred, co-branded drug, you must pay the full cost of the drug unless the prescribing physician requests and obtains authorization for the nonpreferred drug from the BCBSM Pharmacy Services Department.

YOUR COPAYMENT

Your copayment is:

$10 for each generic prescription order or refill.

$20 for each brand name drug even if the prescription is marked "DAW" or if there if no generic equivalent drug available.

CHOOSING YOUR PHARMACY

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs.

Network Pharmacy

In Michigan, a network pharmacy is a pharmacy that is part of the Blue Cross Blue Shield of Michigan Preferred Rx network. In other states, a network pharmacy is a pharmacy that is part of the Medco Health Prescription solutions network. Network pharmacies will file claims for you and they receive payment directly from BCBSM.

When your prescriptions are filled through a network pharmacy, benefits are payable at 100 percent of the approved amount less your copayment.

Important: Pharmacies outside Michigan must use the Medco Health group number below to verify your eligibility, not the five-digit group number on your BCBSM ID card.

PAID Group Number: BCBSMLG

If your pharmacist needs assistance, he or she may call the PAID Provider Help Desk at 1-800-922-1557.

Non-Network Pharmacy

Pharmacies not part of the Preferred Rx or PAID CCN-III network are called non-network. If you go to a non-network pharmacy, you, not the pharmacist, will need to file your claim for payment. You'll receive 75 percent of the BCBSM approved amount less your copayment. You are responsible for any differences between the cost of the prescription or refill and the BCBSM payment.

WHAT'S NOT COVERED

Your Prescription Drug coverage does **not** cover:

- Drugs that cost less than your copayment.
- Administration of covered drugs or any covered drug entirely consumed at the time and place of the prescription.
- Refills not authorized by a physician.
- Any medication that does not require a prescription, except insulin.
- Therapeutic devices or appliances, even if prescribed by a physician (e.g., support garments regardless of their intended use).
- More than a 34-day supply of a covered drug, except for specified maintenance drugs that are covered for 100-unit doses or 200-unit doses (retail pharmacy) or mail order prescriptions that are covered for a 90-day supply.

- Refills dispensed after one year from the date of the original order.
- Prescription drugs that are used primarily for improving appearance rather than for treating a disease.
- Diagnostic agents.
- Any vaccine given solely to resist infectious diseases.
- Any drug BCBSM determines to be experimental or investigational.
- Drugs or services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which you are eligible.
- Drugs or services obtained before the effective date or after the contract ends.
- More than 12 doses of an impotence drug such as Viagra in a 34-day period.
- Nonpreferred co-branded drugs, unless they are preauthorized.

SECTION 10. DENTAL CARE COVERAGE

(Refer to Section 1 for eligibility.)

Dental benefits are designed to promote good dental health through preventive care and regular checkups.

DENTIST PARTICIPATION

Ask your dentist if he or she participates. Participation under the Dental Care Program is on a case-by-case basis. This means your dentist agrees on a "per claim" basis whether or not to accept payment directly from BCBSM for covered services. By indicating "Payment to Dentist" on the claim form, your dentist is agreeing to participate with BCBSM and accept the BCBSM payment as payment in full. You do not have to pay any additional charges. You are responsible only for your copayment and any non-covered services.

If your dentist does not choose to participate with BCBSM, the claim will be submitted indicating "Payment to Subscriber." This means that your dentist may not choose to accept the BCBSM payment in full. This means you are responsible for the difference between your dentist's charge and the BCBSM payment, including any copayments.

PREDETERMINATION

For most dental procedures that have a cost of $200 or more, your dentist should submit a treatment plan showing the services and charges before beginning treatment. The treatment plan is reviewed and your dentist is notified which services are payable.

When you dentist does not request a predetermination, you, as the subscriber, are entitled to ask that a predetermination be submitted. Then you will know if your procedure is an approved service, what BCBSM will pay for the service, and what is your responsibility.

Should you elect to have the initial procedure instead of the alternate procedure recommended by BCBSM, your benefits will be payable up to the amount allowed for the alternate procedure, less any applicable deductible or copayment, and you will be responsible for the remainder of the charge. This process gives you an opportunity to discuss your benefits and payments with your dentist before treatment is started.

BENEFIT PERIOD

A benefit period is based on the calendar year, January 1 through December 31.

COPAYMENTS

For covered dental services, your program pays 50 percent of the approved amount, and your copayment is 50 percent.

DOLLAR MAXIMUM

Dental benefits are subject to a $500 annual dollar maximum, per person. Once the **annual** dollar maximum is met, the Fund will not pay claims for that individual for the balance of the year. They will continue to pay claims for other eligible family members until each individual has met the annual maximum.

WHAT'S COVERED

You have coverage for the following classes of services:

Class I – Preventive Services

Benefits include:

- Oral exams every six months
- Fluoride treatments
- Treatment for relief of pain
- Emergency treatment
- Space maintainers for members under the age of 19
- Bitewing X-rays every six months
- Full mouth X-rays every 36 months
- Teeth cleaning every six months

Class II – Restorative Services

Benefits include:

- Recementing of crowns, inlays, onlays and/or bridges
- Root canal therapy
- Treatment of gums and bones
- Extractions (simple and surgical)
- General anesthesia when administered for oral or dental surgery
- General adjustment and reclining of dentures

- Repair of removable dentures
- Fillings (amalgam, acrylic or silicate)
- Inlays, onlays and crowns

Class III – Construction of Dentures and Bridges

Benefits include:

- Removable dentures (complete and partial)
- Fixed bridges including abutment crowns
- Replacement of dentures and bridges after five years if unserviceable

WHAT'S NOT COVERED

Your Dental Care coverage does **not** cover:

- Charges for missed appointments.
- Charges for the completion of claim forms.
- Services and supplies necessary for the diagnosis or treatment of a dental illness or injury.
- Services that are experimental, investigative, substandard or not approved by the American Dental Association.
- Charges for cleaning of teeth unless done under the supervision of a dentist. (Supervision means the dentist is available but not necessarily at chairside during the procedure.)
- Treatment given by someone other than a dentist.
- Services for cosmetic purposes; personalized services or supplies.
- Charges for veneers placed on crowns or pontics other than the ten lower and ten upper anterior teeth.
- Instruction in oral hygiene, diet control and plaque control.
- Gold foil restorations, implants and periodontal splinting.

- Appliances, restorations or services necessary to increase dimension or restore or correct occlusion or treat jaw-joint disorders.

- Dental services with respect to congenital or developmental malformation or primarily for improving appearance.

- Adjustments of dentures within six months after installation.

- Lost, missing or stolen appliances; repairs and replacement of appliances.

- Charges for duplicate appliances.

- Dental sealants.

- Orthodontic services.

SECTION 11. VISION CARE COVERAGE

(Refer to Section 1 for eligibility.)

Your vision coverage is designed to encourage regular eye examinations and help pay the cost of corrective eyewear.

CHOOSING YOUR VISION PROVIDER

When you need vision care, it is important to find out whether or not your provider participates with BCBSM.

Participating Providers

Blue participating providers have signed agreements with BCBSM to accept the BCBSM approved amount, less your copayment, as payment in full for covered services. Participating providers also file claims for you and receive payment directly from BCBSM. You are only responsible for your copayments and for any special options such as oversized lenses, blended bifocals or designer frames.

To locate a participating vision care provider near you, call the customer service number in Section 2. A representative will be happy to assist you.

Note: Out-of-state providers will be reimbursed according to the approved amounts determined by the provider's local Blue Cross Blue Shield plan.

Nonparticipating Providers

Nonparticipating vision care providers do not have signed agreements with BCBSM and can choose not to accept the BCBSM approved amount as payment in full. This means you are responsible for any difference between the BCBSM approved amount and the provider's charges. This amount is in addition to your copayments. You may also have to file your own claim to receive reimbursement.

YOUR COPAYMENTS

When you receive vision care from a participating provider you are only responsible for:

- A $5 copayment for vision examinations

- A $7.50 copayment for lenses and frames or medically necessary contact lenses.

Tip: If you select lenses and frames that cost more than your coverage allows, such as oversized or designer frames, you are responsible for the cost if it exceeds the BCBSM approved amount. Always ask your provider if you will have any additional costs.

When you receive vision services from a nonparticipating provider payment is limited to:

- 75 percent of the approved amount less your $5 copayment for vision examinations

- A predetermined amount for lenses and frames (you are responsible for any difference between this amount and the provider's charge)

TIME LIMITATION

Vision Care benefits are payable once every 24 months. During this time frame, your coverage will pay for either eyeglasses or contact lenses, but not both.

WHAT'S COVERED

Your vision care benefits include:

Examinations

- Visual acuity tests
- External examination of the eyes
- Tonometry (glaucoma testing)
- Binocular measure
- Ophthalmoscope
- Patient history

Frames

- Wire, plastic, or metal frames – standard size to fit standard lenses

Lenses

- Glass or plastic-equivalent lenses – standard size (less than 65 mm in diameter), single, bifocal, or trifocal vision
- Tints that are medically necessary, equivalent to rose #1 or #2

Contact Lenses

- Hard, soft, or extended wear contact lenses; single or bifocal vision (non-medically necessary lenses are covered up to a maximum of $35)

WHAT'S NOT COVERED

Your Vision Care coverage does **not** cover:

- Special options including oversized lenses, blended bifocals, designer frames, and coatings.
- Medical or surgical treatment.
- Drugs or medications administered for a purpose other than a vision examination.
- Special procedures such as vision training or subnormal-vision aids.
- Services ordered before the effective date of your coverage or lenses and frames delivered more than 60 days after your coverage ends.
- Vision testing examinations, lenses or frames for any condition, disease, ailment, or injury related to your employment or an act of war.

- Sunglasses, photosensitive, or anti-reflective lenses that cost more than the benefit for regular lenses. Benefits are payable only up to the amount approved for standard lenses.

- Charges for tints that are not medically necessary.

- Special lenses.

SECTION 12. HEARING CARE COVERAGE

(Refer to Section 1 for eligibility.)

Your hearing care coverage is designed to identify hearing problems and provide benefits for corrective hearing devices.

CHOOSING YOUR HEARING PROVIDER

When you need hearing care, it is important to find out whether or not your provider participates with BCBSM. **Hearing benefits are covered only when services are received from a participating provider**. Call the customer service number in Section 2 for names of participating providers.

TIME LIMITATION

Hearing care benefits are payable once every 36 months.

WHAT'S COVERED

Hearing Care benefits are paid at 100 percent of the approved amount only when the services are received in the following order:

- First, **you must** have a medical examination of the ear performed by a participating board-certified or board-eligible otologist, otolaryngologist or otorhimolaryngologist. **This examination is a medical benefit**.

- Then, within six months, you must receive the following services from a **participating provider in the order listed**:

    1. **Audiometric examination** – measures hearing ability, including tests for air and bone conduction, speech reception, and speech discrimination

    2. **Hearing aid evaluation** – determines what type of hearing aid should be prescribed to compensate for loss of hearing

    3. **Ordering and fitting the hearing aid** – includes in-the-ear, behind-the-ear, and basic

hearing aids worn on the body, with ear molds, if necessary

4. **Conformity test** – evaluates the performance of a hearing aid and its conformity to the original prescription after it has been fitted

WHAT'S NOT COVERED

Your Hearing Care coverage does **not** cover:

- Your medical examination to determine possible loss of hearing. (This examination is a medical benefit.)
- An examination by an audiologist that has not been ordered by a physician specialist.
- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates.
- Replacement of hearing aids that are lost or broken, unless this occurs after 36 months when benefits are renewed.
- Repairs and replacement of parts.
- The difference in cost between an eyeglass-type hearing aid and a behind-the-ear hearing aid.
- All hearing care services and supplies provided by a nonparticipating provider.
- Charges for digital-controlled programmable hearing devices beyond the amount Blue Cross pays for a basic hearing aid.
- Hearing aids that do not meet Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements.

SECTION 13. MEDICARE COVERAGE FOR ELIGIBLE MEMBERS

MEDICARE COVERAGE

Medicare is a federal health care program designed to provide health care benefits to persons who are 65 or older, to persons who have end stage renal disease (ESRD) and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a "beneficiary".

You become eligible for Medicare when you are 65 (or earlier if you are disabled or have ESRD). If you are eligible by reason of age, you may enroll at any time during a seven-month period. This period begins three months before the month in which you reach 65, and includes the actual month of your birthday and the three months following your birthday month. During this period, you must apply for Medicare through your local Social Security Administration office.

Medicare coverage has two parts: hospital insurance (Part A) and medical insurance (Part B). Hospital insurance helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Medical insurance helps pay for physician's services and other medical services and items.

In order to continue your coverage through the Fund, you must enroll in both Parts A and B of Medicare.

The hospital insurance portion is provided at no cost to you. However, you must pay monthly for the medical insurance portion. This premium is adjusted annually. You will be notified of the change before each new year.

Employed Persons Aged 65 or Older

When you reach 65 and become eligible for Medicare, but are still eligible through a Fund of 20 or more persons, you have two options for health care coverage.

You may:

1. Continue your regular current coverage as your primary health care plan, or

2. Select Medicare as your primary health care plan.

The following explains these options:

Option 1

You may continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue this coverage.

Important: If you continue to be covered through your fund for your primary health care benefits, you should still apply for Medicare benefits, especially Part A.

- Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide additional benefits to your group coverage.

- Part B of Medicare, the medical insurance, is available for a monthly premium. However, you can delay enrollment in Part B without penalty.

If you delay in enrolling for Medicare Part B coverage when you reach 65, you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your group plan and ends two months later.

Option 2

You may select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibits your Fund from providing you with Medicare Supplemental coverage. You must file a written notice with your Fund Office and with Medicare if you choose this option.

Reminder: If you have a spouse who is 65 or older and is covered under your health plan, your Fund must provide the same coverage you select for your spouse until you retire or leave employment.

MEDICARE SUPPLEMENTAL COVERAGE

If you have Supplemental coverage, it works with your Medicare coverage to extend your health care benefits.

What's Covered

You have coverage for the following:

- Part A benefits

  - **Inpatient hospitalization** – covers your Medicare Part A deductible and coinsurance required from the 61st day through the 90th day of a hospital admission. It also extends the number of your inpatient days to 365.

  - **Lifetime reserve days** – covers the daily coinsurance required by Medicare.

  - **Skilled nursing care** – covers the daily coinsurance required by Medicare for days 21 through 100.

- Part B benefits

  - **Physician care** – covers the yearly deductible required by Medicare and 20 percent of Medicare's reasonable charge except for home care, office calls, and injections.

  - **Outpatient psychiatric care** – covers the special 37.5 percent coinsurance required by Medicare in addition to the 20 percent coinsurance for physician care.

What's Not Covered

Your Medicare Supplemental coverage does **not** cover:

- Custodial nursing care (such as help with walking, getting in and out of bed, eating, dressing, bathing, and taking medications) at home or in a nursing home.

- Intermediate nursing care in a nursing home.

- Private duty nursing or skilled nursing care not approved by Medicare.

- Physician charges that are more than Medicare's allowed amount.

- Injury or sickness covered by Workers Compensation.
- Admissions or care provided by a government-owned or – operated hospital unless payment is required by law.
- Admissions that begin before the effective date of coverage.
- Admissions that begin after the coverage termination date.
- Medical care, services or supplies provided or furnished while coverage is not in effect (that is, before the effective date of coverage or after the coverage termination date).
- Drugs other than prescription drugs furnished during your stay in a hospital or skilled nursing facility.
- Dental care, dentures, routine physicals and immunizations, cosmetic surgery, routine foot care, and examinations for eyeglasses or hearing aids.
- Office calls, chiropractic adjustments and injections.

SECTION 14. HOW TO FILE A CLAIM

When you use your benefits, a claim must be filed before payment can be made. Participating providers should automatically file all claims for you. All you need to do is show your BCBSM ID card. However, nonparticipating providers may or may not file a claim for you.

To file your own claim, follow these steps:

1. Ask your provider for an itemized statement with the following information:

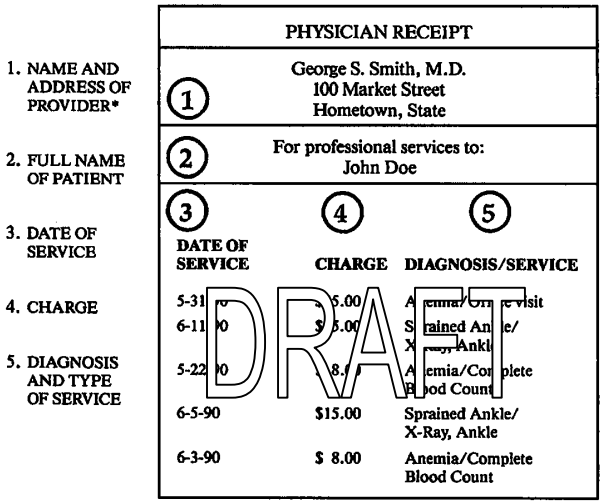
    - Patient's name
    - Subscriber's name and contract number (from your ID card)
    - Provider's name, address, phone number, and federal tax ID number
    - Date and description of services
    - Diagnosis (nature of illness or injury)
    - Admission and discharge dates for hospitalization

    Important: If you receive medical services out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks, or money order stubs may accompany your itemized statement, but may not substitute for an itemized statement.

2. Make a copy of all items for your files and send the original to BCBSM at the address in Section 1. It is important that you file claims promptly because most services have a two-year filing limitation.

    Important: You will receive payment directly from BCBSM. The check will be in the subscriber's name, not the patient's name.

The example below shows the information BCBSM requires in order to review your claim:



**Include tax identification number for out-of-state physician.*

**If the provider's office is located outside Michigan, include the provider's tax ID number.*

If the patient does not have Medicare coverage, send all of the claim information to:

Blue Cross Blue Shield of Michigan
Major Groups Customer Service Center
600 E. Lafayette Blvd., Mail Code **X420**
Detroit, MI 48226

EXPLANATION OF BENEFIT PAYMENTS (EOBP)

After BCBSM processes claims for services you receive, you will receive an Explanation of Benefit Payments (EOBP). The EOBP is not a bill. It is a statement that helps you understand how your benefits were paid. At the top of the EOBP you'll find BCBSM customer service numbers and an address to use for inquiries. Briefly the EOBP tells you:

- The family members who received services.
- The date services were provided ("claims processed from ….to….").

- **"Summary of Balances"** includes the provider(s) of the services, detail about charges and payments, including the amount saved by using participating providers.

- **"Summary of Deductibles and Copayments"** provides your deductible and copayment requirements as well as deductibles and copayments paid to date.

- **"Helpful Information"** includes messages and reminders.

- **"Detail on Services"** summarizes the BCBSM payment and shows your balance.

If you see an error, contact your provider first. If he or she cannot correct the error, call the customer service number on your EOBP.

If you think your provider is intentionally billing BCBSM for services you did not receive, or that someone is using your card illegally, contact the BCBSM Anti-Fraud Hotline:

- In Michigan, call 1-800-482-3787

- Outside Michigan, call 1-313-225-8100. Your call will be transferred to the BCBSM Anti-Fraud Unit.

Your call is strictly confidential. By working together, we can help keep health care costs down.

EXAMPLE OF EOB

THIS IS NOT A BILL

Blue Cross Blue Shield of Michigan

Statement Date: 06/13/98

81828-001
SMITH, JOHN
123 ELM LANE
FOREST PK OH 45240

Your Customer Service Phone Number Is:
NATIONWIDE TOLL-FREE 1-800-843-4876

Send Written Inquiries to this Address:
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
STATE OF MICHIGAN
P.O. BOX 80380
LANSING MI 48908-0380

Group Name:
Group Number: 81828-001
Subscriber Name: SMITH, JOHN
Contract Number: 123456789
Coverage: HOSPITAL/PHYSICIAN

See your Health Care Benefits Certificate or Benefits Guide for details on contract coverage.

Patient Name: SUSAN
Patient Birth Month/Year: 10/30

Summary of Balances (See Detail on Services)

Name of Hospital, Physician or Provider	Total Provider Charges	(-) Less BCBSM Paid	(-) Less Participating Provider Savings	(-) Less Other Insurance Paid	(=) Equals Your Balance*
UNIV FAM PHYSICIANS WYOM	74.00	9.20	22.88	40.90	1.02
Totals:	$ 74.00	$ 9.20	$ 22.88	$ 40.90	$ 1.02

*Note: The amount in the 'Equals Your Balance' column includes any copayments, deductibles, sanctions and non-covered charges.

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Helpful Information

Naturally Blue provides discounts on select alternative medical services and natural products. Call 1-888-718-7011.

Detail on Services Contract Number: 123456789 Patient: SUSAN

Service Date (From/To): 07/10/96
Claim Received on: 08/16/96
Provider Name: UNIV FAM PHYSICIANS WYOM
Provider Status: NOT APPLICABLE
Referring Provider:
Service Type: OFFICE CALLS
Procedure: OFFICE/OUTPATIENT,ES
Procedure Code: 99214
Claim Number: 81537654321

Total Charge	$	74.00
Amount approved by Medicare for this service		**51.12**
Amount Medicare covered		**40.90**
Amount considered by BCBSM for this service		**10.22**
Minus copayment		**-1.02**
BCBSM processed on 8/22/96 and paid provider		**9.20**
Basic $ 0.00		
MM $ 9.20		
Savings because provider participates with Medicare	+	**22.88**
Total Covered	$	**72.98**
Your Balance: (Highlighted Amounts)	$	**1.02**

Explanation Message: We reduced our payment because your contract requires a 10 percent Major Medical copayment for the service. (YM10)

COORDINATION OF BENEFITS (COB)

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

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

How COB Works

If you are covered by more than one group plan, COB guidelines (explained below) determine which carrier pays for covered services first.

- Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under the plan.

- Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by the carriers.

GUIDELINES TO DETERMINE PRIMARY AND SECONDARY PLANS

Contract Holder Versus Dependent Coverage

The Plan that covers the patient as the employee (subscriber or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts)

If you are the contract holder of more than one health care plan, your primary plan is the one of which you are an active member (such as an employee), and

your secondary plan is the one of which you are an inactive member (such as a retiree).

Dependents (The "Birthday Rule")

If a child is covered under both their mother's and father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.

Children of Divorced or Separated Parents

For children of divorced or separated spouses, benefits are determined in the following order unless a court order places financial responsibility on one parent:

1. Plan of the custodial parent..
2. Plan of the custodial parent's new spouse (if remarried).
3. Plan of non-custodial parent.
4. Plan of non-custodial parent's new spouse.

If the primary plan cannot be determined by using the guidelines above, then the "birthday rule" will be used to determine primary liability.

Filing COB Claims

Remember to ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to the secondary carrier. When you submit claims to BCBSM for reimbursement of the balance, please follow these steps:

1. Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.
2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.

4. Make sure the provider's name and complete address are on your receipts. If the provider is in Michigan, include the provider's BCBSM identification number (PIN). If the provider is located out of Michigan, include the provider's tax ID number.

5. Send these items to:

   Blue Cross Blue Shield of Michigan
   COB Department, Mail Code B570
   600 E. Lafayette Blvd.
   Detroit, MI 48226-2998

Please make copies of all forms and receipts for your own files, because BCBSM cannot return the originals to you.

Updating COB Information – Your Responsibility

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify your Fund Office immediately. BCBSM may periodically ask you to update your COB information. Please help BCBSM serve you better by responding to requests for COB information quickly.

SUBROGATION

In certain cases, another person, insurance carrier or organization may be legally obligated to pay for health care services that BCBSM has paid. When this happens:

- Your right to recover payment from them is transferred to BCBSM.

- You are required to do whatever is necessary to help BCBSM enforce their right of recovery.

- If you receive payment through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBSM. However, this does not apply if the funds you receive are from additional coverage you purchased in your name from another insurance company.

NO-FAULT AUTO INSURANCE AND BCBSM COVERAGE

If you or an eligible dependent are involved in a motor vehicle accident, payment for medical services will be coordinated between BCBSM and your auto insurance carrier as follows:

- Whether your auto coverage is coordinated or uncoordinated, your auto insurance carrier is primary. BCBSM will be secondary to your no-fault auto insurance. It is important that you discuss this with your auto insurance company.

SECTION 15. GLOSSARY – TERMS YOU SHOULD KNOW

Accidental Injury – Physical damage caused by an action, object or substance outside the body. This includes strains, sprains, cuts and bruises; allergic reactions, frostbite, sunburn, and sunstroke; swallowing poison and medication overdosing; and inhaling smoke, carbon monoxide, or fumes.

Acute Care Facility – A facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days. The facility is not primarily for:

- Custodial, convalescent, or rest care
- Care of the aged
- Skilled nursing care or nursing home care
- Substance abuse treatment

Allogeneic (Allogenic) Transplant – A procedure using another person's bone marrow or peripheral blood cells to transplant into the patient (including syngeneic transplants when the donor is the identical twin of the patient).

Ambulatory Surgery Facility – A separate outpatient facility that is not part of a hospital, where surgery is performed and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Approved Amount – The Blue Cross Blue Shield of Michigan maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copayments are deducted from the approved amount.

For prescription drugs, the approved amount is the lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug or service. The drug cost and dispensing fee are set according to the BCBSM contracts with the pharmacy. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments that may be required of you are subtracted from the approved amount before BCBSM makes their payment.

Approved Facility – A hospital or clinic that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care,

or physical therapy. Approved facilities must meet all applicable local and state licensing and certification requirements. Approved facilities must be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. These facilities must also meet all applicable local and state licensing and certification requirements and have been approved as a provider by Blue Cross Blue Shield of Michigan.

Approved Hospital – A hospital that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Autologous Transplant – A procedure using the patient's own bone marrow or peripheral blood stem cells for transplantation back into the patient.

Blue Cross and Blue Shield Association (BCBSA) – An Association of independent Blue Cross and Blue Shield Plans that licenses individual Plans to offer health benefits under the Blue Cross Blue Shield name and logo. The Association establishes uniform financial standards but does not guarantee an individual Plan's financial obligations.

Blue Cross Blue Shield of Michigan (BCBSM) – A non-profit, independent company, one of many individual Plans located throughout the United States committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community based public and subscriber members.

Benefit – Coverage for health care services available in accordance with the terms of your health care coverage.

Clinical Trial – A study conducted on a group of patients to determine the effect of a treatment. It generally includes the following phases:

- Phase I – a study conducted on a small number of patients to determine what the side effect(s) and appropriate dose of treatment may be for a certain disease or condition.

- Phase II – a study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.

- Phase III – a study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Contraceptive Device – A device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.

Coordination of Benefits (COB) – A program that coordinates your health benefits when you have coverage under more than one group health plan.

COBRA – Continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Copayment – The designated portion of the approved amount you are required to pay for covered services. This can be either a fixed dollar or percentage amount.

For prescription drugs, the copayment is the portion of the approved amount that you must pay for a covered drug or service. Your copayment amount is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Note: A separate copayment is not required for covered disposable needles and syringes when dispensed at the same time as insulin or chemotherapeutic drugs.

Covered Services – Services, treatments or supplies identified as payable in your certificate and riders. Covered services must be medically necessary to be payable, unless otherwise specified.

Custodial Care – Care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating, taking medicine, etc. This care may be given with or without:

- Routine nursing care
- Training in personal hygiene and other forms of self-care
- Care supervised by a physician

Deductible – A specified amount that you pay during each benefit period for services before your plan begins to pay.

Designated Cancer Center – A site approved by the national Cancer Institute (NCI) as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated Facility – A facility that Blue Cross determines to be qualified to perform a specific organ transplant.

Durable Medical Equipment – Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury. A physician must prescribe this equipment.

Emergency First Aid – The initial examination and treatment of conditions resulting from accidental injury.

End State Renal Disease (ESRD) – Permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Experimental or Investigative – A service, procedure, treatment, device, or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. Blue Cross Blue Shield of Michigan makes this determination based on a review of established criteria such as:

- Opinions of local and national medical societies, organizations, committees, or governmental bodies
- Accepted national standards of practice in the medical profession
- Scientific data such as controlled studies in peer review journals or literature
- Opinions of the Blue Cross Blue Shield Association or other local or national bodies

Freestanding Facility – A facility separate from a hospital that provides outpatient services, such as substance abuse treatment, rehabilitation, skilled nursing care, or physical therapy.

Freestanding Outpatient Physical Therapy Facility (OPT) – An independently owned and operated facility, separate from a hospital, that provides outpatient therapy services and occupational or functional occupational therapy or speech and language pathology.

High-Dose Chemotherapy (HDC) – A procedure that involves giving a patient cell destroying drugs in doses higher than approved by the FDA for therapy.

Hospital – A facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

Independent Physical Therapist (IPT) – A licensed physical therapist that is not employed by a hospital, physician, or freestanding outpatient physical therapy facility and who maintains an office, separate from a hospital or freestanding outpatient physical therapy facility, with the equipment necessary to adequately provide physician-prescribed physical therapy.

Medical Emergency – A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

Medical Necessity – A service must be medically necessary in order to be payable by your health care coverage. Medical necessity definitions for hospital services and medical services follow:

Medical necessity for payment of **hospital services** requires that all of the following conditions be met:

- The covered service is for the treatment, diagnosis, or symptoms of an injury, condition, or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
- Appropriate means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting:

- The services are not mainly for the convenience of the member or health care provider.

- The treatment is not generally regarded as experimental or investigative by Blue Cross Blue Shield of Michigan.

- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment Programs.

Important: In some cases, you may be required to pay for services even when they are medically necessary. These limited situations are:

- When you don't inform the hospital that you are a Blue Cross Blue Shield member either at the time of admission or within 30 days after you are discharged.

- When you fail to provide the hospital with information that identifies your coverage.

Medical necessity for payment of **physician services** is determined by physicians acting for their respective provider types and/or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

- The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.

- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition, or illness. It is not mainly for the convenience of the member or physician.

- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

- In the absence of established criteria, medical necessity will be determined by physician or professional review according to generally accepted standards and practices.

- The Blue Cross Blue Shield of Michigan determination of medical necessity for payment purposes is based on standards of practice established by physicians.

Member – Any person eligible for health care services under your plan. This includes you as the subscriber and any of your eligible dependents listed in Blue Cross Blue shield membership records.

Negotiated Price – In most cases, the "negotiated price" is a simple discount arrangement.

Some Blue Plans use an estimated price that factors in expected settlements with health care providers or provider groups. Or "negotiated price" may reflect average expected savings, which the Blue Plan periodically adjusts to correct for past over-or underestimation of prices. In addition, a few states require their local Blue Plan(s) to calculate payments in such a way that the entire discount may not be passed on to BCBSM for each claim. When you receive health care services in these states, your payment and any deductible or copayment will be based on the method required by law.

Network Pharmacies – Pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Preferred Rx network (in Michigan) or Merck-Medco Managed PAID Prescriptions Coordinated Care Network Level III (CCN III) network (outside Michigan). Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

Non-Network Pharmacies – Pharmacies that are not a member of the Preferred Rx (in Michigan) or PAID Prescriptions CCN III (outside Michigan) networks. Non-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

Nonparticipating Providers – Providers that have not signed participation agreements with Blue Cross Blue Shield of Michigan agreeing to accept the Blue Cross Blue Shield of Michigan payment as payment in full. However, nonparticipating professional (non-facility) providers may agree to accept the Blue Cross Blue Shield of Michigan approved amount as payment in full on a per claim basis.

Occupational Therapy – Treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints.

- Help the patient apply the restored or improved function to daily living.

Participating Providers – Providers that have signed agreements with Blue Cross Blue Shield to accept the Blue Cross Blue Shield of Michigan-approved amount for covered services as payment in full.

Patient – The subscriber or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Per Claim – A provider's acceptance of the Blue Cross Blue Shield-approved amount as payment in full for a specific claim or procedure.

Peripheral Blood Stem Cell Transplant – A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

Physical Therapy – Treatment that is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Reminder: Physical therapy is not covered when services are principally for the general good and welfare of the patient (e.g., developmental therapy or activities to provide general motivation).

Physician – A medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DD) or doctor of medical dentistry (DMD).

Professional Provider – A medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical dentistry (DMD) or a fully licensed psychologist.

Provider – A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Rider – A legal document that amends a certificate by adding, limiting, or clarifying benefits.

Routine Service – Procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.

Skilled Nursing Facility – A facility that provides convalescent and short-or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Specialty Hospital – A hospital, such as a children's hospital, a chronic disease hospital, or a psychiatric hospital, that provides care for a specific disease or population group.

Speech Therapy – Active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Stem Cells – Primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subscriber – The person who signed and submitted the application for Blue Cross Blue Shield coverage.

Substance Abuse – Taking alcohol or other drugs in amounts that can:

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

You and Your – Used when referring to any person covered under the subscriber's contract.

BCBSM CERTIFICATES AND RIDERS

C 3315-CMM-LTM
C 4084-RDR CMM SAT II
C 408703-RDR GPC SAT II
C4398-BONE MRRW TRANS
C 501503-CMM 100 90/10
C 5220-SUBR02
C 5227-HMN
C 5401-SOCT
C 5423-END STAGE RENAL
C 554102-CMM-MHDVCMM1009
C 5821-ASFP
C 6003-ICMP
C 6502-65 OPT 2
C 7021-HOSPICE
C729201-PTFS-CMM
C 7559-NFAX3
C 9770-GRP CONTINU OPT
C 990903-SOT-PE
C 993009-GLE-1
D 3509-PD-CR $10.00
C 350965-PD-CR $10.00-65
D 3607-PREFERRED RX
D 360765-PREFERRED RX 65
D 513814-PDCM PDCR $10.00
Q 7104-DXTMJ
Q K008-K008
Q K00865-K008-65
S 0738-65 OPTION 1
S 3315-CMM-LTM
S3687-CERT NURSE PRAC
S 3691-RDC
S 3693-TECH SURG ASST
S 4084-RDR CMM SAT II
S 408703-RDR GPC SAT II
S 4398-BONE MRRW TRANS
S 4791-HEARING CARE
S 479165-HEARING CARE
S496403-RIDER CMM-PDC-1
S 4965-RIDER CMM-PDC-2
S 501503-CMM 100 90/10
S 507008-CMM-VST
S 5216-ECIP
S 5220-SUBRO2
S 5385-CRNA
S 5401-SOCT
S 5423-END STAGE RENAL
S 554102-CMM-MHDVCMM1009
S 621701-PTS-CMM
S 6600-CNM
S 665110-CMM-100-90-RPS
S 7108-CMM XTMJ
S 7469-RAPS
S 7559-NFAX3
S 7562-MAMMOGRAMS
S 9770-GRP CONTINU OPT
S 9973-PCD
V 477004-AUTO 80 VISION
V 477065-AUTO 80 VISION
BCP BCP-PPO
MLOS COB2B
SD FC
C17LDDG 07/01/1996
S1RRBE 07/01/1996
C17LDG 07/01/1996
S1RRBE 07/01/1996

Service Key	Effective Date
C17LDG	07/01/1996
S1RRBE	07/01/1996

SECTION 16. STATEMENT OF PARTICIPANT'S RIGHTS

Information Required by the Employee Retirement Income Security Act (ERISA)

As a participant in the Michigan BAC Health Care Fund, 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 work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

You can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12)

months (eighteen [18] months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal Court. In such case, the Court may require the Plan Administrator to provide the materials and pay you up to One Hundred Ten Dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical

Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. you may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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SECTION 17. OTHER IMPORTANT INFORMATION

The Trustees Interpret the Plan

Under the Trust Agreement creating the Welfare Fund, and the terms of this Plan, the Board of Trustees have the sole authority to interpret the Trust Agreement and the Plan and to make final determinations regarding any application for benefits and the interpretation of the Plan and any administrative rules adopted by the Trustees. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Trust, and the Welfare Plan provides, that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Any interpretation of the Plan's provisions rests solely with the Board of Trustees. Benefits under this Plan will be paid only if the Trustees decide, in their discretion, that the applicant is entitled to them. **No employer or union**, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board nor can an employer or union act as an agent of the Board of Trustees.

However, the Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from participants regarding eligibility rules, benefits, and claims procedures, But, if there are any questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination.

The Plan Can be Changed

The Trustees have the legal right to change the Plan, subject to any collective bargaining agreement that applies to it.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To do so may require Plan changes from time to time.

Changes in the Plan may also be required in order to preserve the Fund's tax-exempt status under Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, the Trustees may find it necessary to change Plan provisions so that the Trust does not lose its tax-exempt status.

Your Plan is Tax Exempt

Your Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the employers contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not taxable as personal income. Also, investment earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption works to the benefit of both employer and employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan "Qualified" as a tax exempt Trust under Internal Revenue Service rules.

Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of this Plan or the similar terms of any other plan, the Fund may, without consent or notice to any covered person, release to or obtain from any insurance company or other organization or individual, any information, with respect to any covered person, which the Fund deems to be necessary for such purposes. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

HIPAA Privacy Rule

Under federal law, health plans (like this one) must comply with the HIPAA Privacy Rule ("Privacy Rule") concerning the use and disclosure of Protected Health Information (also known as "PHI"). This Plan has taken the necessary steps to achieve such compliance. The Privacy Rule also requires that Plan to issue a Privacy Notice explaining the Plan's Privacy policies and your rights under the Privacy Rule. The Plan's Privacy Notice contains a detailed listing of such information. If you need another copy of this Notice, please contact the Fund Office.

Right of Recovery

Whenever payments have been made by the Fund with respect to allowable expenses in excess of the maximum amount of payment necessary at the time to satisfy its provisions, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following the Fund shall determine:

1. Any individual to whom or from whom such payments were made; or

2. Any insurance company, hospital, physician or any other organization.

The Fund may also recover such excess payments by reducing future benefit payments, if any, which become due a Participant, Dependent or Beneficiary.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which are prescribed herein effective at the time of payment. If no such designation or provision is then effective, the indemnity will be payable to the estate of the Employee. Any other accrued indemnities unpaid at the Employee's death may, at the option of the Trustees, be paid either to the beneficiary or to the estate.

Subject to any written direction of the Employee, all or a portion of any indemnities provided by the Fund for services rendered by a hospital, nursing, medical, surgical, dental or vision service may, at the Trustees' option, and unless the Employee requests otherwise in writing no later than the time for filing proof of loss, be paid directly to the hospital or provider of services.

Name of the Plan

The Plan is the Michigan BAC Health Care Fund.

Type of Plan

This Plan provides Health Care Benefits for expense due to hospitalization, surgery, medical treatment, vision or dental care. This Plan also provides benefits for Weekly Accident and Sickness (Loss of Time).

Type of Plan Administration

The Plan is administered and maintained by the Board of Trustees. The Trustees have selected a professional employee benefits administrative firm as the Administrative manager of the Plan. The Administrative Manager is responsible for carrying out the Trustees' policy decisions, recordkeeping, accounting and paying most benefits subject to the Plan Document.

Name and Address of Administrative Manager

The Administrative Manager selected by the Trustees is:

TIC International Corporation
6525 Centurion Drive
Lansing, Michigan 48917
Telephone: (517) 321-7502
Fax: (517) 321-7508
Toll Free: (800) 531-2244

Section 18. Claims Review & Appeal Procedures

Your Right to Receive an Explanation of and to Ask for Review of an Adverse Benefit Determination

Your or your provider must fie claims for Fund Medical Benefits with Blue Cross Blue Shield of Michigan. Claims for other benefits (such as death benefits) are filed with the Fund Office.

If you have questions about decisions made on claims or requests for Medical benefits, you can address them by telephone to one of BCBSM's Customer Service Representatives. Their telephone number is in the top right hand corner of the first page of the Explanation of Benefits sent to you by BCBSM and also in BCBSM's letter notifying you that your claim for benefits has not been approved.

If you have questions about decisions made on claims of requests for other Fund benefits, you should address them by telephone to one of the Fund Office's claims representatives. Their telephone number is (800) 531-2244.

If you are not satisfied that BCBSM's or the Fund Office's denial of your request for benefits was proper, the Employee Retirement Income Security Act of 1974, as amended ("ERISA") requires that you can ask for review or appeal that "adverse benefit determination."

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial based on your eligibility to participate in the Plan. You may ask for review of or appeal an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

A "pre-service claim" is a claim for a benefit conditioned, in whole or in part, on obtaining advance approval of medical care.

An "urgent care claim" is a claim for medical care or treatment where applying the normal time periods for claims determination could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that you are seeking.

A claim will be found to be an urgent care claim if either (1) a physician with knowledge of your medical condition determines that the claim is an urgent care claim or (2) the Plan using the judgment of a prudent layperson with average knowledge of health and medicine determines that it is an urgent care claim.

A "post-service claim" is any claim that is not a pre-service claim or an urgent care claim.

You must follow the review procedure set forth below to appeal or obtain review of an adverse benefit determination on pre-service, post-service and urgent care claims. Except for appeals or requests for review of adverse benefit determinations involving urgent care claims, all appeals or requests for review must be in writing. You normally must follow these review procedures before you can file a civil lawsuit under ERISA to get a court to order the Plan to provide you with the benefits that you have requested.

Medical Benefit Claim Review Procedure

A. Review Procedure – Post-service claims

This review procedure has a two-step appeal process. It is triggered when the Plan provides you with a written adverse benefit determination, which must be done within 30 days of the Plan's receipt of your claim.

Level 1. To start a Level 1 review, you, or your authorized representative, must send a written statement to BCBSM explaining why you disagree with the Plan's adverse benefit determination to BCBSM. The mailing address is found at the top right hand corner of the first page of your Explanation of Benefits form.

You must include in your request all documents, records or comments that you believe support your position. You must request review no later than 180 calendar days after you receive the Plan's decision on your claim for benefits. BCBSM will respond to your request for review within 30 days unless BCBSM tells you in writing that it needs additional time. If you agree with BCBSM's response, it becomes a final determination and review of your claim ends.

Level 2. If you disagree with BCBSM's Level 1 response to your request for review, you may request a review by the Plan's Trustees at Level 2. You must request Level 2 review in writing no later than 30 calendar days after you receive B and in the letter we sent notifying you that the Plan has not approved a benefit or service that you have requested BCBSM's Level 1 determination.

You must mail your request to the address specified in the letter that BCBSM sends to you to notify you that BCBSM has not approved your request for review at Level 1. You must include as part of your Level 2 request for review all documents, records and comments that you feel support your position. You will receive a written determination of your Level 2 request for review by the later of (a) the Plan's next regularly scheduled meeting which is at least 30 days after the date of your Level 1 request for review or (b) 30 days following your request for Level 2 review unless the Trustees tell you that they need more time. The written determination that you receive as a result of your Level 2 request for review will be the final determination involving your claim for benefits.

If you disagree with the Plan's Level 2 determination, or a Level 2 determination is not issued by the time required, or the procedures for Level 1 or Level 2 review are not followed by the Plan, you have the right to bring a civil lawsuit under ERISA Section 502 (a) to try to obtain the benefits that you have requested.

B. Review Procedure – Pre-service claims

1. The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that BCBSM must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. A determination will be issued within 15 calendar days of receipt of your request for a level 1 review, and within 15 calendar days of your request for a level 2 review. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

2. If you disagree with the final determination, or if the determination at each level is not issued within the 15 day time frame or the review procedures for level 1 and level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

C. Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call your customer service number for assistance (see Section 2).

2. BCBSM must provide you with their decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including the BCBSM decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If the BCBSM decision is communicated orally, they must provide you or your authorized representative with written confirmation of their decision within 2 business days.

3. If you disagree with the BCBSM final determination or if they fail to issue the determination within 72 hours, or otherwise fail to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits. In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims.

   a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure."

   b. No fees or costs may be imposed as a condition to requesting review.

   c. Although there are set timeframes within which you must receive the final determination on all three types of claims, you have the right to allow additional time if you wish.

   d. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claims for benefits.

e. You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.

f. The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.

g. If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.

h. Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.

i. On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.

j. If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.

k. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.

l. If your health plan provides for any voluntary appeal procedures beyond the level 2 review, you will be advised of those procedures in the level 2 response.

Claim Review Procedure for Other Benefits

The Plan's review procedure for these claims has a one-step appeal process. It is triggered when the Plan provides you with a written adverse benefit determination, which must be done within 180 calendar days of the Plan's receipt of your claim. The Plan's Appeals Committee will decide your request no later than its first regular meeting that is at least 30 days after the Trustees receive your appeal. The written determination that you receive as a result of your Level 2 request for review will be the final determination involving your claim for benefits.

If you disagree with the Plan's determination, or a determination is not issued by the time required, or the procedures for review are not followed by the Plan, you have the right to bring a civil lawsuit under ERISA Section 502(a) to try to obtain the benefits that you have requested.

APPENDIX

BOARD OF TRUSTEES

Employer Trustees

Duane Bremer
Gerace Construction Company
4055 South Saginaw Road
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Bob Fontana
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Norway, MI 49870

Steve Fournier
Edgar Boettcher Mason Contractor
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Traverse City, MI 49686-6043

Marty Iskra
Yalmer Mattila Contracting, Inc.
57 North Huron, Box 456
Houghton, MI 49931

Josef Korzilius
Industrial Firebrick Corp.
625 Ann Street, NW
Grand Rapids, MI 49504-2012

Employee Trustees

James Bitzer
BAC Local No. 9
3321 Remy Drive
Lansing, MI 48906

David Blake
4878 Mackinaw Road
Saginaw, MI 48603

Daryl Hollenback
BAC Local No. 9
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Lansing, MI 48906

Nelson McMath
1404 Industrial Park Road
Suite 2
Saline, MI 48176

Gary Roberts
BAC Local No. 6
119 S. Front Street
Marquette, MI 49855

OTHER FUND CONTACTS

Fund Office

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6525 Centurion Drive
Lansing, MI 48917-9275

Administrative Manager

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6525 Centurion Drive
Lansing, MI 48917-9275

Legal Counsel and Agent for Service of Process

Christopher Legghio
Martens, Ice, Geary, Klass, Legghio, Israel & Gorchow
1400 North Park Plaza Building
17117 West Nine Mile Road
Southfield, MI 48075