Michigan Electrical Employees' Health Plan

Summary Plan Description

January 1, 2024

Summary Plan Description Booklet
Michigan Electrical Employees' Health Plan

Restated effective January 1, 2024

For More Information
Or Further Assistance Please Call the Plan Office At:

Toll Free at (855) 633-4584 or (952) 854-0795 Or Write:

Michigan Electrical Employees' Health Plan
c/o Wilson McShane Corporation
3001 Metro Drive Suite 500
Bloomington, MN 55425
www.michiganelectrical.org

Business Hours: Monday through Friday 9:00 a.m. - 6:00 p.m. Eastern Time

You can also contact the Trustees in writing by sending correspondence to:
Michigan Electrical Employees Health Plan
Board of Trustees
c/o 1423 East Twelve Mile Road
Madison Heights, MI 48071

To All Plan Participants: This booklet describes the benefits for Employees, retired Employees and Eligible Dependents of Employees and retired Employees under the Michigan Electrical Employees' Health Plan (the "Plan"), effective as of January 1, 2024. This booklet is both the Plan's Summary Plan Description and Plan Document. It includes information about Employee benefits, eligibility, self-payment rules, Plan changes that were made after your last booklet was printed, and other important information. It also tells you how to file a claim for benefits and what action you can take if you are denied benefits.

The benefits provided under the Plan are self-funded. Self-funded benefits payable are limited to Plan assets available for such purposes. The Board of Trustees of your Plan constantly works to provide you with the best health care coverage possible within the financial means of the Plan. Benefits under the Plan are not vested or guaranteed. The Board of Trustees have the right in their sole discretion to amend, modify, interpret, or delete benefits, self-payment rates, eligibility rules, or any other provisions relating to the operation of the Plan or to terminate the Plan, in whole or in part, at any time by written amendment. If there should be any conflicts or inconsistencies between this booklet and the actual provisions of the Trust Agreement, the provisions of the Trust Agreement will govern.

Only the Board of Trustees has authority and reserves the right to answer questions about eligibility and benefits, to interpret the Plan or any other provisions relating to the operations of the Fund. The Board has delegated some of this authority to the Plan Office staff, Blue Cross Blue Shield of Michigan ("BCBSM"), and Delta Dental in this regard. The Plan Office staff, the BCBSM, and Delta Dental staff do their best to answer your questions, see that your claims are paid as promptly as possible, and notify you of important information.

Be sure to read this booklet carefully (have your spouse read it, too) and keep it with your other important papers for future reference.

Sincerely,
Board of Trustees
Michigan Electrical Employees' Health Plan

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Introduction

The benefits described in this booklet, the BCBSM Community Blue PPO Benefits-at-a-glance ("BAAG") document, the Delta Dental Summary of Benefits (including Delta Vision) and the Plan's legal documents are available to you and your Eligible Dependents through your participation in the Plan. The Plan provides the following benefits:

- Employee Medical Benefits
- Retiree Medical Benefits
- Weekly Disability Benefits
- Dental Benefits
- Vision Benefits
- Vision Discount Program
- Health Reimbursement Arrangement (*i.e.*, Special Fund)
- Death Benefits
- Accidental Death and Dismemberment ("AD&D") Benefits

This booklet is complete only when it also includes the BAAG and the Delta Dental Summary of Benefits. Please keep this document with your BAAG, Delta Dental Summary of Benefits and other information about the Plan.

Doing Your Part

As a participant in this Plan, you have certain responsibilities in order to protect your eligibility and to receive your benefits from the Plan.

1. Read this booklet. Please read this entire document carefully to familiarize yourself with your eligibility rules, benefits, etc.

2. Submit a Participant Data Form. One of your most important responsibilities is to see that the Plan Office always has current information about you and your Dependents. This information is necessary for you to get your I.D. cards, for BCBSM and a Delta Dental ID card (if applicable to you), to verify coverage for benefits, and for the Plan Office to send you COBRA coverage notices as well as other important information, such as notices about changes in your Plan. To ensure that your information is current, you must:

   - Complete a Participant Data Form and return it to the Plan Office immediately if you are a new covered Employee.
   - Periodically, complete a new Participant Data Form and return it to the Plan Office to update the Plan Office records.
   - Complete a new Participant Data Form and return it to the Plan Office immediately if there is any change in address for you or a Dependent, or if there is a change in your family status because of marriage, birth or adoption of a Child, death, divorce or legal separation, or a Child losing Dependent status.

   You can get a Participant Data Form from the Plan Office or at michiganelectrical.org.

3. Use your I.D. cards. You and your spouse should each carry a BCBSM I.D. card (which shows the IBEW symbol), and a Delta Dental ID card (if applicable to you). Any time you receive medical care, dental care (if applicable to you) or fill a prescription, show the card to the Hospital, Doctor, pharmacy, etc.

4. Keep copies of all bills and EOBs**.** It is important that you keep a copy of all bills and Explanation of Benefits ("EOB") forms, especially if you submit the originals to BCBSM, Delta Dental or the Plan Office.

Personal Pronouns Used in this Booklet

Words used in this booklet in the masculine gender (he, him, his) or feminine gender (she, her, hers) will be considered as the feminine gender or masculine gender, respectively, where appropriate. Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

Definitions

Most of the definitions included below are Plan Definitions, but some BCBSM definitions have been included and are marked with a (*). BCBSM's definitions of some of the other Plan terms may be different from the Plan's definitions. While some of these differences may affect the processing of your claim by BCBSM, the Plan's definition will ultimately govern.

When a word or phrase defined below is used in this booklet, the definition shown below for that word or phrase will apply unless stated otherwise in another part of this booklet.

ACA. The Patient Protection and Affordable Care Act and all correspondence regulatory and subregulatory guidance.

Alumni Employee. An Employee who once participated in the Plan because of work performed under a Collective Bargaining Agreement. To be an Alumni Employee, an Employee must satisfy the following criteria:

1. The Employee must be performing services which are not covered under a Collective Bargaining Agreement for an Employer that is signatory to a Collective Bargaining Agreement, the Union or the Plan, must not be represented by a labor organization but whose Employer has a valid participation agreement with the Trustees requiring the Employer to make contributions to the Plan on behalf of the Employee.

2. The Employee was a collectively bargained Employee for all employment while working in a position covered by the Collective Bargaining Agreement.

3. The Employee was covered as an Employee under the Plan for a period of at least one Plan Year while covered by the Collective Bargaining Agreement.

The Employee participated in the Plan under a Collective Bargaining Agreement or participation agreement within 36 months of the date on which the Employee is enrolled as an Alumni Employee.

***Ambulatory Surgery Facility.** A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient Hospital care. It is not an office of a Physician or other private practice office.

Appendix. The Appendix located at the end of this booklet. The Appendix shall be considered a part of the Plan and shall be subject to the terms of the Plan.

Association. The Michigan Chapter, National Electrical Contractors' Association, Inc., divisions participating in the Plan.

***Approved Amount.** The maximum charge that BCBSM will consider when calculating benefits. Generally, it is the lower of the billed charge or the Maximum Payment Level for the covered service. Copayments and/or Deductibles, which may be required of you, are subtracted from the Approved Amount before the Plan will make payment.

***Approved Clinical Trial.** Phase I, II, III or IV Clinical Trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition (*i.e.*, a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted), and includes any of the following:

1. A federally-funded trial, as described in the Patient Protection and Affordable Care Act

2. A trial conducted under an investigational new drug application reviewed by the Food and Drug Administration

3. A drug trial that is exempt from having an investigational new drug application

4. A study or investigation conducted by a federal department that meets the requirements of section 2709 of the Patient Protection and Affordable Care Act

***BCBSM.** Blue Cross Blue Shield of Michigan. (The Plan has contracted for provider discounts and certain administrative duties with BCBSM.)

Bargaining Unit Employee. A person who is an Employee of an Employer for whom the Employer is required to make contributions to the Plan under a Collective Bargaining Agreement.

Benefit Component. A written benefit program maintained by the Michigan Electrical Employees' Health and Welfare Plan to provide health and welfare benefits to its Eligible Employees, Retirees and/or Dependents. Such Benefit Components are referenced in the Appendix, and specifically are incorporated into the Plan by this reference. Each Benefit Component is governed by its terms. In the case of any conflict between this Plan document and such Benefit Component, the Plan document shall prevail.

***Benefit Period.** The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant related prescription drugs, must be provided during this period of time.

Calendar Year. The 12-month period starting on January 1 of any year and ending on December 31 of that same year.

***Case Management.** A program that is designed to help manage the health care of members with acute or chronic conditions. It is up to BCBSM to decide whether you qualify for this program.

In certain circumstances, BCBSM may find it necessary to pay for services that are generally not covered by your contract but that are Medically Necessary to treat your condition. When this occurs, a Case Management contract must be signed by you (or your representative), your provider and the BCBSM case manager. This contract will define the services that will be covered under the Case Management program.

Note: If BCBSM has contracted with a vendor to manage the Case Management program, then that vendor will make decisions regarding Case Management and sign any necessary Case Management documents on behalf of BCBSM.

Child. An individual who is:

1. The Employee's natural Child.

2. The Employee's legally adopted Child or a Child placed with the Employee for the purpose of adoption.

3. The Employee's stepchild.

For purposes of this definition, the term "Eligible Employee" or "Employee" shall be construed to include an Eligible Retiree.

***Clinical Trial.** A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, Clinical Trials include:

1. Phase II - a study conducted on a 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.

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

***Coinsurance.** The portion of the Approved Amount that you must pay for a covered drug or service. This amount is determined based on the Approved Amount at the time the claims are processed. Your Coinsurance is not altered by an audit, adjustment, or recovery. For prescription drugs, your Coinsurance is not reduced by any coupon, rebate, or other credit received directly or indirectly from the drug manufacturer.

Collective Bargaining Agreement. The negotiated labor agreements between a Union and the Association or an Employer requiring contributions to the Plan.

***Copayment.** The dollar amount that you must pay for a covered drug or service. Your Copayment is not altered by an audit, adjustment, or recovery. For prescription drugs, your Copayment is not reduced by any coupon, rebate, or other credit received directly or indirectly from the drug manufacturer.

***Cost Sharing.** Copayments, Coinsurances, and Deductibles you must pay under the Plan.

Covered Employment. Work that you perform for an Employer for which the Employer is required to make contributions to the Plan for you.

Covered Individual. A person who is eligible to receive Plan benefits applicable to his status as an Eligible Employee, Eligible Retiree or Eligible Dependent.

Credited Hour. A Credited Hour includes the following:

1. Any reported hour for which a contribution is made to the Plan on your behalf.

Exception - if an Employer that is required under a Collective Bargaining Agreement to make contributions to the Plan hires you outside of the Local Union hiring process under the Collective Bargaining Agreement, the hours you work will not be considered Credited Hours for initial or continuing eligibility purposes, even though the Employer makes contributions for those hours.

2. Any hour for which you make a regular self-payment to the Plan to continue your Plan coverage.

3. For "Eligibility During Disability," any hour of work credited to you by the Plan for continuing your coverage but for which neither you nor your Employer has made a contribution. No partial days will be credited.

Dependent. An individual who is:

1. An Eligible Employee's lawful spouse, which the Plan recognizes in a manner consistent with governing law. The Plan recognizes the marriage of an Eligible Employee to a same-sex spouse that was valid in the jurisdiction where it was entered into regardless of whether the Eligible Employee is domiciled in a stated that recognizes same-sex marriages;

2. An Eligible Employee's Child until the last day of the month in which the Child attains age 26;

3. An Eligible Employee's Other Dependent, which includes a Grandchild until the last day of the month in which the Grandchild attains age 26;

4. An Eligible Employee's disabled unmarried Child or unmarried Other Dependent age 26 or older, provided the Child or Other Dependent must:

    - Be Dependent on the Employee for more than half of his or her annual financial support;
    - Be incapable of self-support due to an intellectual disability, mental incapacity, or physical handicap;
    - Have become disabled while a Covered Individual;
    - Remain disabled; and
    - Have the same principal residence as the Employee for more than half the Calendar Year except for temporary absences under special circumstances such as education or, alternatively, is not considered to be a "qualifying Child" of the Employee or another taxpayer.

    If a Child or Other Dependent meets these conditions, he will remain a Covered Individual as long as the Employee remains eligible.

    If the Employee or his spouse apply for Social Security benefits, the Employee should request Medicare coverage for his disabled Child or Other Dependent. If approved, and after the applicable

waiting period for Medicare coverage, this Plan's benefits for the Child or Other Dependent would be coordinated with Medicare until the Employee becomes covered under the Medicare Advantage Benefit. At that time, the Child or Other Dependent would also be covered under the Medicare Benefit, subject to the applicable eligibility rules.

5. An "alternate recipient" under a Qualified Medical Child Support Order or a National Medical Support Notice as determined by the Trustees with which the Plan must comply or a Child for whom an Employee is required by a domestic relations order or other court order to provide primary health benefits and who is under age 26.

A Child or Other Dependent must be a citizen or national of the United States or a resident of the United States, Canada or Mexico. This provision does not exclude an adopted Child who does not meet the citizenship criteria if the Child has the same principal residence as the Employee, is a member of the Employee's household and the Employee is a citizen or national of the United States.

In their sole discretion, the Trustees may require an Employee to submit acceptable proof that a Child or Other Dependent is a Dependent before a claim for the Child or Other Dependent will be processed.

For purposes of this definition, the term "Eligible Employee" or "Employee" shall be construed to include an Eligible Retiree.

***Deductible.** The amount that you must pay for covered services, under any certificate, before benefits are payable. Payments made toward your Deductible are based on the Approved Amount at the time of the claims are processed. Your Deductible is not altered by an audit, adjustment, or recovery. For prescription drugs, your Deductible is not reduced by any coupon, rebate, or other credit received directly or indirectly from the drug manufacturer.

***Designated Cancer Center**. A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your Physician upon request.

Doctor; Physician. A legally qualified Physician or surgeon who is a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.) or a Doctor of Chiropractic (D.C.). Also considered a Doctor with regard to performing certain oral surgical procedures due to accidental injury or trauma is a Doctor of Dental Surgery (D.D.S.) and, for services performed only within the scope of the individual's license, a Doctor of Podiatric Medicine (D.P.M.). In addition, to the extent required by the ACA, the term "Physician" shall also include a health care provider who is not an M.D., or a D.O. or D.C. but who is licensed to provide such services in the state in which the services are performed and who is acting within the scope of that provider's license or certification under applicable state law.

Eligible Dependent. Any Dependent who is entitled to receive benefits applicable to his or her eligibility status under this Plan.

Eligible Employee. An Employee who has met the Plan's eligibility requirements and is entitled to receive the benefits provided under the Plan for Employees.

Eligible Retiree. A Retiree who meets the applicable eligibility requirements established by the Trustees for coverage under the Early and Disability Retiree Benefits or the Medicare Advantage Program.

***Emergency Medical Condition.** A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

1. The health of the patient (or with respect to a pregnant woman, the health of the woman or her unborn Child) to be in serious jeopardy, or

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another Hospital before delivery or the transfer may pose a threat to the health and safety of the woman or unborn Child)

***Emergency Services.** Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a Hospital, and include ancillary services routinely available in a Hospital's emergency room to evaluate an Emergency Medical Condition. They also include, within the capabilities of the staff and facilities available at the Hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

Employee. As further defined in the Agreement and Declaration of Trust, a person who is employed by a Contributing Employer that is required under a Collective Bargaining Agreement or participation agreement to make Contributions to the Plan for the Employee.

Employer; Contributing Employer. As further defined in the Agreement and Declaration of Trust, a sole proprietor, Association, partnership, corporation or related trust fund which is primarily engaged in the electrical industry and which enters into a Collective Bargaining Agreement or participation agreement providing for contributions to the Plan on behalf of its Employees.

***Experimental Treatment.** Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services." See page 100 for additional information on what is considered "experimental."

Grandchild. The Grandchild of an Eligible Employee who satisfies all of the following requirements:

1. maintains a permanent residence in the Employee's home for more than one-half the Calendar Year except for temporary absences under special circumstances such as education;

2. is Dependent on the Employee for more than half of his or her annual financial support and maintenance;

3. is required to participate in the Plan pursuant to either a Qualified Medical Child Support Order or court order that appoints the Employee as the Grandchild's guardian responsible for maintaining health coverage; **and**

4. has previously qualified as a Dependent eligible for coverage in the Plan as a biological Child of an Employee.

***Hospice.** A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

***Hospital.** A facility that:

1. provides inpatient or outpatient diagnostic, therapeutic, and surgical services for injured or acutely ill persons:

2. is fully licensed and certified as a Hospital, as required by all applicable laws: **and**

3. complies with all applicable national certification and accreditation standards.

Hospital services must be provided by or under the supervision of a professional staff of licensed Physicians, surgeons and registered nurses.

Note: A facility that provides specialized services that does not meet all of the above requirements does not qualify as a Hospital under this certificate, regardless of its affiliation with any Hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional Children or for the treatment of the aged or those with substance use disorder
- Skilled nursing facilities or other nursing care facilities

***In-Network Mail-Order Provider.** A provider selected by BCBSM to provide covered drugs through the PPO program. In-Network Mail-Order Providers have agreed to accept the Approved Amount as payment in full for the covered drugs provided to members enrolled in the PPO mail-order program.

***In-Network Pharmacy.** A provider selected by BCBSM to provide covered drugs through the PPO program. In-network pharmacies have agreed to accept the Approved Amount as payment in full for covered drugs or services provided to members.

***Life-threatening Condition.** Any disease or condition from which the likelihood of death is probable unless the course of the disease of condition is interrupted.

***In-Network Providers.** Providers that are in the BCBSM PPO network. These providers have signed agreements with BCBSM to accept the BCBSM Approved Amount for covered services as payment in full.

***Long-Term Acute Care Hospital.** A specialty Hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

***Maximum Allowable Cost (MAC).** The most BCBSM will pay for certain covered drugs identified under the Maximum Allowable Cost Program, which is a BCBSM cost containment program that encourages the use of generic drugs. The MAC Program places a cost limit on certain drugs for which a generically equivalent drug is available at a lower cost.

***Maximum Payment Level.** The most BCBSM will pay for a covered service. For participating or In-Network Providers, it is the amount BCBSM pays the provider under the provider's contract with BCBSM. For services provided by nonparticipating or Out-of-Network Providers, it is the amount BCBSM pays for the service to its participating or In-Network Providers or the amount BCBSM negotiates with the nonparticipating or out-of-network provider. Maximum Payment Level is not a "Medicare-like rate" described in 42 C.F.R. §136.30, et. seq.

***Medically Necessary.** A service must be Medically Necessary to be covered.

Medical necessity for payment of professional provider and other provider services:

Health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; **and**

3. Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

Note: "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician or provider society recommendations and the views of Physicians or providers practicing in relevant clinical areas and any other relevant factors.

Medical necessity for payment of Hospital and LTACH services

Covered Hospital services will be considered medical necessary when all of the following conditions are met:

1. The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease;

2. 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;

3. 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.

4. The service is not mainly for the convenience of the member or health care provider;

5. The treatment is not generally regarded as experimental by BCBSM; **and**

6. The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to Hospitals, not to LTACHs).

Medical necessity for prescription drugs

A drug must be Medically Necessary to be covered, as determined by pharmacists and Physicians acting for BCBSM, based on criteria and guidelines developed by pharmacists and Physicians for BCBSM. The covered drug must be accepted as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or prescriber. In the absence of established criteria, medical necessity will be determined by pharmacists and Physicians according to accepted standards and practices.

Medicare. The Health Insurance for the Aged Program under Title XVIII of the Social Security Act and the Social Security Amendments of 1965, as this Program is currently constituted and as it may later be amended.

Non-Bargaining Unit Employee. A Non-Bargaining Unit Employee includes:

1. An Employee of a participating Employer who is not a member of a bargaining unit but who's Employer has a valid participation agreement with the Trustees requiring the Employer to make contributions to the Plan on behalf of the Employee. One specification of the participation agreement is that this Plan be the only coverage provided by the Employer; and

2. An Employee of a participating Union who is not subject to a Collective Bargaining Agreement, provided the Union has a valid participation agreement with the Trustees requiring the Union to make contributions to the Plan on behalf of the Employee; and

3. A salaried apprenticeship instructor or coordinator of a Joint Apprenticeship Training Committee ("JATC") training program that has a valid participation agreement with the Trustees requiring contributions to be made on such person's behalf.

4. An Employee of a related trust fund that has a valid participation agreement with the Trustees requiring the trust fund to make contributions to the Plan on behalf of related trust fund's Employees.

***Out-of-Network Mail-Order Provider.** A provider who has not been selected to provide covered drugs through the PPO program. Out-of-Network Mail-Order Providers have not agreed to accept the Approved Amount as payment in full for covered drugs provided to members in the PPO mail-order program.

***Out-of-Network Pharmacy.** A provider that has not been selected for participation and has not signed an agreement to provide covered drugs through the PPO program. Out-of-network pharmacies have not agreed to accept the Approved Amount as payment in full for covered drugs provided to members.

***Out-of-Network Providers.** Providers that have not signed agreements with BCBSM to accept the BCBSM payment as payment in full. However, out-of-network professional (non-facility) providers may agree to accept the BCBSM Approved Amount as payment in full on a per-claim basis.

Prescription Drug Assistance Program. Prescription Drug cost saving programs including, but not limited to, Manufacturer Copayment Assistance Programs, Non-Profit Foundation Copayment Grants, Manufacturer Free Drug Programs, Disease-Based Healthcare Grants, Government-Sponsored Programs, and Prescription Savings Clubs including organizations such as Amazon, GoodRx, etc.

Plan. The self-funded Michigan Electrical Employees' Health Plan described in this booklet.

***Qualified Individual.** An individual eligible for coverage under this certificate who participates in an Approved Clinical Trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

1. The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol: **or**

2. The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols.

Retiree. An Employee who was eligible for benefits under the Plan at least three of the five years prior to the date of such Employee's retirement and such Employee is either retired under the retirement provisions of an industry-sponsored pension Plan, retired under the disability provisions of the Social Security Program or is a retired Non-Bargaining Unit Employee who is at least age 55 at the time he retires from employment in the industry.

***Routine Patient Costs.** All items and services related to an Approved Clinical Trial if they are covered under this certificate (or any riders that amend it) for members who are not participants in an Approved Clinical Trial. They do not include:

1. The investigational item, device, or service itself:

2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient: **or** A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Totally Disabled; Total Disability. For you, the Employee, being Totally Disabled means that you are completely unable to perform any and every duty associated with your occupation or employment as a result of non-occupational accidental bodily injury or sickness. For the sole purpose of receiving disability hours, the Total Disability may be due to either an occupational or non-occupational cause.

For a Dependent or a Retiree, being Totally Disabled means that the person is completely unable to perform the normal activities of a person of like age and sex as a result of non-occupational accidental bodily injury or sickness.

Trustees. The Union and Employer Trustees who are responsible for the operation of the Trust Fund through which this Plan of benefits is provided.

Union. The Local Unions affiliated with the International Brotherhood of Electrical Workers (IBEW), AFL-CIO, which are listed on page 146.

Working Owner. A Non-Bargaining Unit Employee or Alumni Employee of an Employer who maintains an ownership interest in the company.

Eligibility

Work Months and Coverage Months

The Plan has a month-to-month eligibility system with a basic requirement of 135 Credited Hours per month for Bargaining Unit Employees. There is an administrative lag month between each work month and its corresponding coverage month.

135 Credited Hours in This Work Month	Earns Eligibility for this Coverage Month
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Initial Eligibility

Bargaining Unit Employees

If you are a Bargaining Unit Employee, you and your Dependents will become initially eligible for Plan coverage on the first day of the coverage month corresponding to the work month in which you first accumulate at least 135 Credited Hours earned in a single month. The same rule applies if you are reinstating your coverage after losing your eligibility. You cannot use disability hours or make Self-Payments to gain initial eligibility or to re-establish eligibility.

Example - If you start work in April and have 135 Credited Hours from working that month, you will become eligible for coverage on June 1 and will be covered through June 30. (June 1 is your "Initial Eligibility Date.")

Cable Pullers and Residential and Motor Shop Trainees

If you are a Cable Puller or Residential Trainee or Motor Shop Trainee, the work months and coverage months described above apply to you. You will become eligible for Plan coverage on the first day of the coverage month corresponding to the work month for which a sufficient monthly contribution is made to the Plan on your behalf.

Non-Bargaining Unit Employees

If you are a Non-Bargaining Unit Employee, the work months and coverage months described above apply to you also. However, your Employer must make monthly contributions on your behalf in an amount equal to 160 hours times 100% of the current base contribution rate. Therefore, unless you are covered under the special Early Eligibility Program for new Non-Bargaining Unit Employees, described on page 23, you and your Dependents will become initially eligible for Plan coverage on the first day of the coverage month corresponding to the work month for which your Employer makes the required monthly contribution. You cannot use disability hours or make Self-Payments to gain initial eligibility or to re-establish eligibility.

An Employer that participates for its Non-Bargaining Unit Employees must pay contributions on behalf of all Non-Bargaining Unit Employees except where such Employee is covered as a Dependent under other coverage or where there is an addendum to a Collective Bargaining Agreement (which must be on file with the Plan Office) that does not require Plan contributions for a specific job classification. If you are an individual who is exempted from participation by such an addendum, you may enroll in the Plan only during the one-month enrollment period during June of each year which would provide coverage beginning as of August 1.

Working Owners

If you are a Working Owner, you are considered to be a Non-Bargaining Unit Employee and subject to the rules for such Employees, unless you opt out of Non-Bargaining Unit Employee coverage pursuant to the rules described on page 12 of this booklet.

If you are a Working Owner and you do not elect to opt out of coverage as a Non-Bargaining Unit Employee, you must report and remit contributions at the rate for Non-Bargaining Unit Employees for yourself.

Late Enrollment Due to Other Coverage

If, on the earliest date you could be eligible under the Plan as a Non-Bargaining Unit Employee you are covered as a Dependent under another Employer-provided group health Plan or health insurance, you may waive coverage under this Plan at that time if you can provide acceptable proof that you are enrolled as a Dependent under another group health Plan. If you are otherwise eligible to participate and want to participate in this Plan after your other coverage ends due to loss of eligibility for reasons such as death, divorce, termination of employment, change in employment status, termination of the Employer's contribution toward the coverage or exhaustion of coverage under COBRA, you must request enrollment no later than 30 days following the date your other coverage ends. To apply for late enrollment under this rule, you must contact the Plan Office and submit proof of the other coverage's effective and termination dates to the Plan Office.

If a Non-Bargaining Unit Employee declined coverage under the Plan due to coverage as a Dependent under a spouse's Employer-provided group health Plan, the Non-Bargaining Employee may enroll under the Plan in an open enrollment period during July each year.

Special Enrollment

You or your Dependents may enroll under the Plan during a special enrollment period if:

1. You and your Dependents are otherwise eligible for coverage;

2. You or your Dependent did not enroll when first eligible because of other health coverage and either later had a loss of eligibility for such coverage or Employer contributions toward such other coverage were terminated;

3. You acquire a Dependent through marriage, birth, adoption, or placement for adoption;

4. You or your Dependent had other coverage under Medicaid or the State Children's Health Insurance Program ("CHIP") and lost eligibility for that coverage;

5. You or your Dependent became eligible for financial assistance through Medicaid or CHIP for coverage under the Plan; or

6. You or your Dependent was on COBRA continuation coverage under another Plan, but COBRA eligibility for you or your Dependent expired.

You or your Dependent must request enrollment, within 30 days of the event described in numbers 2 and 6, 60 days of the events described in numbers 4 and 5, or six months of the event described in number 3. Your Employer must provide coverage for the Dependent at the time enrollment is requested and any other requested information in a timely manner. If you enroll on a timely basis, the effective date of coverage under this Plan will be, as applicable, the date of marriage; birth or adoption or placement for adoption or, for all other special enrollment events, the first day of the month following receipt of the request for enrollment.

Reciprocity/Home Funding

The Trustees are authorized to enter into reciprocal agreements with other Employee benefit trust funds providing similar benefits to those provided by the Plan. The Plan participates in the IBEW Reciprocal Agreement along with other IBEW welfare funds and other reciprocal arrangements that the Trustees have entered into with health and welfare funds (a "Reciprocal Agreement").

If you leave employment covered by the Plan for employment by an Employer that is also a party to a Reciprocal Agreement, you may elect to continue coverage under the Plan by completing the reciprocity authorization as set forth in the Reciprocal Agreement. If you make such election, this Plan will be considered your "Home Fund."

Your eligibility for the transfer of contributions to and from this Plan is limited to the extent required by the applicable Reciprocal Agreement. If you elect to continue coverage in this Plan, the health and welfare fund to which your Employer contributes will transfer contributions it receives on your behalf to this Plan. This Plan will apply your transferred contributions toward your eligibility requirements under this Plan. You will receive

Credited Hours under this Plan for the same number of hours you earned under the other health and welfare fund.

The IBEW uses the Electronic Reciprocal Transfer System ("ERTS") to handle reciprocity transfers. If you leave employment covered by the Plan and are employed in employment covered under the IBEW Reciprocal Agreement and you want this Plan to be your Home Fund, you should register with ERTS. You can register at any IBEW Union office. ERTS is not available for transfers under non-IBEW Reciprocal Agreements. For reciprocity transfers not covered under the IBEW Reciprocal Agreement, you must complete a reciprocity authorization form.

The Plan will also transfer contributions received on behalf of an Employee who has directed the transfer of contributions under a Reciprocal Agreement to another Plan that qualifies as such Employee's home fund in the manner set forth in the applicable Reciprocal Agreement. Employees electing to transfer contributions out of this Plan are ineligible for any benefits or Credited Hours from the Plan on account of such contributions.

There may be some instances in which your Employer enters into an agreement requiring it to contribute directly to the Plan for work outside the Plan's geographic jurisdiction. This is known as "home funding." Contributions transferred under a home funding arrangement will be considered Credited Hours to the extent they equal the contribution rate in effect under the Plan.

When Coverage Starts (Effective Date of Benefits)

All Employees

Your coverage under the Plan will normally start on the date you become initially eligible under the rules described in Initial Eligibility section of this Summary (*i.e.*, your Initial Eligibility Date). There is an exception for Weekly Disability Benefits if you are disabled on your Initial Eligibility Date, which is described on page 26 of this booklet.

Dependents

For coverage of a Dependent to be effective as of your Initial Eligibility Date, you must enroll your Dependents in the Plan within 90 days of your Initial Eligibility Date. If your Dependent is enrolled after the 90-day period expires, the Dependent's effective date of coverage will be the first day of the month following the month in which the Dependent is enrolled.

To enroll in the Plan, you must complete and return to the Plan Office any required enrollment forms and furnish any necessary documentation, such as a marriage certificate or birth certificate. The Trustees may require that an Employee provide acceptable proof that an individual qualifies as a Dependent eligible for coverage under the Plan before the individual will be considered a Eligible Dependent.

Opt-Out Rules for Working Owners

The Plan allows Employers to provide certain Working Owners an annual opt-out election. A Working Owner may annually elect, for the 12-month period that coincides with the Plan Year, to opt out of coverage under the Plan as a Non-Bargaining Unit Employee and to participate in the Plan pursuant to the terms of the applicable Collective Bargaining Agreement provided the following conditions are satisfied:

1. The Collective Bargaining Agreement permits the Working Owner to work in a bargaining unit position;

2. The Working Owner is performing bargaining unit work;

3. The Working Owner notifies the Plan and Local Union in writing at least 2 months prior to the Plan Year for which he desires to opt out of coverage as a Non-Bargaining Unit Employee;

4. The company maintains records identifying the hours the Working Owner works in bargaining unit work and contributes to the Plan for those hours pursuant to the terms of the Collective Bargaining Agreement.

5. The company reports taxable wages paid to the working owner; passive income (e.g., income reported on Form K-1) is insufficient.

Opt-Out Rules for Dependent Spouse Enrolled in HDHP/HSA

A Dependent spouse of an active Employee may elect to opt out of coverage under this Plan if he or she is enrolled in either a High Deductible Health Plan ("HDHP") that is offered by the Dependent spouse's Employer in conjunction with an Health Savings Account ("HSA"). To opt-out of this Plan, the Dependent spouse must:

1. Complete and sign a Spousal Coverage Opt-Out Form acknowledging that he or she is opting out of coverage under this Plan and its Special Fund; and

2. Provide the Plan Office with acceptable proof the spouse is enrolled in an Employer-provided HDHP offered in conjunction with an HSA.

3. The Dependent spouse's coverage under this Plan (including the Special Fund) will terminate at the end of the last day of the month in which the Plan Office receives a completed and signed Spousal Coverage Opt-Out Form.

4. The Dependent spouse's opt-out election will automatically renew each year until the spouse reinstates coverage under the Dependent spouse Opt-In Rules, set forth below.

5. If a Dependent spouse elects to opt out of coverage under this Plan, no Special Fund reimbursement will be made for any health care expenses incurred by the spouse, even if such expense would qualify as a reimbursable expense under the Special Fund.

6. Any self-payments required for Plan coverage are not reduced under the Plan's spousal opt-out provision.

Opt-In Rules for Dependent Spouse Previously Enrolled in HDHP/HSA

A spouse who has opted out of Plan coverage in accordance with the Opt-Out provisions above may later reinstate coverage as a Dependent under the Plan, including its Special Fund, provided the spouse's coverage under the HDHP with HSA Plan of his or her Employer has terminated and the spouse provides satisfactory written proof of the same to the Plan Office; and the spouse continues to qualify as an Eligible Dependent.

Coverage under this Plan as a Dependent will be effective for the spouse on the first day of the month following the date the Plan Office receives a completed and signed Opt-In Form and satisfactory proof of coverage and termination under the HSA Plan. The Plan will not cover any health care expenses incurred by the spouse prior to the effective date of the reinstatement of coverage.

Continuing Eligibility

Basic Rules

Bargaining Unit Employees

Once you become eligible, you and your Dependents will remain eligible during each successive coverage month if you have at least 135 Credited Hours in the corresponding work month. For example, you will be eligible in October if you have 135 Credited Hours in August.

Non-Bargaining Unit Employees

Once you become eligible, you and your Dependents will remain eligible during each successive coverage month if your Employer makes the required monthly contribution to the Plan on your behalf for the corresponding work month.

As explained above, monthly contributions must equal 160 hours multiplied by 100% of the current base contribution rate, regardless of the actual number of work hours reported. For example, 160 hours contributed for the August work month will make you and your Dependents eligible for coverage in October.

Cable Pullers and Residential and Motor Shop Trainees

Once you become eligible, your eligibility continues as long as sufficient Employer contributions are made on your behalf.

Rollback Rule

Bargaining Unit Employees

If you do not meet the basic 135-hour rule, your eligibility can also be continued if you have an average of 135 hours going back over a period of up to 12 months under the rollback rule. The rollback rule also applies to Cable Pullers and Residential and Motor Shop Trainees. The rollback rule works like this:

If you do not have 135 hours in a work month, the hours from the month before that work month are added to the hours you have for that work month. If the total hours for the two months combined is at least 270 hours, then your eligibility will be continued.

If your two-month total is less than 270, then your hours for the month before those two months are added to the previous total. If the three-month total is at least 405, then your eligibility will be continued.

The rollback process continues in this way. In each step your next prior month's hours are added, and the total is compared to the next highest multiple of 135.

For example - you will be eligible in January 2020 if you have any of the following:

135 hours	in ….	November 2018
270 hours	in ….	October 19 - November '19
405 hours	in ….	September '19 - November '19
540 hours	in ….	August '19 - November '19
675 hours	in ….	July '19 - November '19
810 hours	in ….	June '19 - November '19
945 hours	in ….	May '19 - November '19
1080 hours	in ….	April '19 - November '19
1215 hours	in ….	March '19 - November '19
1350 hours	in ….	February '19 - November '19
1485 hours	in ….	January '19 - November '19
1620 hours	in ….	December '19 - November '19

Credited Hours from COBRA self-payments or credited disability hours are NOT counted under the rollback rule.

Non-Bargaining Unit Employees

Your coverage will NOT be extended using the rollback rule (or the regular self-payment rules described below), unless either you were a Covered Individual for at least the prior 36 consecutive months; or you are an Alumni Employee.

Payroll Deductions for Deficit Contributions

Your Employer's Collective Bargaining Agreement includes a "Maintenance of Benefits" provision. This means that if the cost of the Plan increases over the total amount that the Employers are contributing to the Plan for their Employees, the Employer contribution rate will be increased to an amount that will "maintain" Plan benefits at the current level.

If the Plan cost goes up and the contribution rate is increased, your Employer may not be obligated to pay the new rate until after a specific date stated in the Collective Bargaining Agreement. If this happens, you will have to pay the "deficit amount"—the difference between what your Employer pays per hour and the amount of the new hourly contribution rate. Your Employer will deduct this "deficit amount" from your paycheck and pay it to the Plan Office along with the regular contribution for you.

If your Employer fails to send the full amount of the contribution to the Plan Office, you might lose your coverage for the month for which payment should have been made, or your level of coverage could be reduced.

Self-Payment Options

If your coverage under the Plan is going to terminate, you can make self-payments to continue coverage. There are two types of self-payments:

1. Regular self-payments; and

2. COBRA self-payments.

These self-payment methods are explained in the next two sections.

Regular Self-Payments (Bargaining Unit Employees Only)

If you are a Bargaining Unit Employee and have become eligible to participate in the Plan but your Credited Hours are insufficient to meet either the 135-hour rule or the rollback rule, you can make self-payments to cover the gap.

Rules Governing Regular Self-Payments

The following rules apply to making regular self-payments:

1. Each self-payment you make applies for one month of continued coverage.

2. Self-payments must be made for the number hours you are short of 135 hours in the applicable work month, times 50% of the current base contribution rate. The contribution rate used to determine your self-payment is the base hourly rate not including the Special Fund. The rollback rule is not considered when calculating the amount due.

3. All regular self-payments will be payable at the same rate. That is, your number of "short hours" multiplied by the product of the base contribution rate multiplied by 50%. Your "short hours" are the exact number of hours needed to satisfy the 135-hour rule.

4. Self-payment amounts must be paid in full based on the established rate.

5. Self-payments are payable by a check or money order made payable to the: Michigan Electrical Employees' Health Plan. You can also authorize the Plan to deduct your required self-payment from your Special Fund (see paragraph 13 on page 16). Payment for the correct amount and the self-payment billing form, which you can obtain from by the Plan Office, must be received by the Plan Office *no later than the 15th day of the month in which your eligibility would terminate due to not working sufficient hours.* You and your Dependents will not be covered until the Plan Office receives the required payment. However, once the Plan Office receives your timely self-payment, your coverage will be retroactively reinstated as of the first day of the coverage month.

Note: The Plan Office sends statements to provide you the information needed to make regular self-payments (or COBRA self-payments) if you want to continue your Plan coverage. These statements are sent only for your convenience. It is YOUR RESPONSIBILITY to keep track of your eligibility and hours worked and to contact the Plan Office if you don't have enough hours. If you have fewer than 135 reported hours in a work month and you have not received a statement, contact the Plan Office immediately if you want to make a regular self-payment. The Plan Office is not responsible if you do not receive a statement and fail to make a timely regular self-payment. If you fail to make a regular self-payment by the 15th day of the month in which your eligibility would terminate due to not working sufficient hours or in which you receive the statement from the Plan Office (if applicable), you may still be entitled to make a COBRA self-payment for COBRA coverage according to the rules in the next section.

6. Hours for which you make a regular self-payment will be counted as regular Credited Hours for the purpose of the 135-hour rule and the rollback rule.

7. Regular self-payments can be made for a maximum of 9 consecutive months. Extensions will not be granted, except as described below If you are still not working sufficient hours after your self-pay period ends, you can elect COBRA continuation coverage for an additional 18 months. Months for which you made a regular self-payment will not count toward the 18-month COBRA maximum.

8. You can make regular self-payments only if you are available for work within the jurisdiction of the Local Unions participating in this Plan or if you are working under a Reciprocal Agreement.

9. The benefits provided by regular self-payments are continued medical and prescription drug benefits and dental and vision benefits (if applicable) for you and your Dependents and continued coverage for you under the Weekly Disability Benefit and Death and AD&D Benefits.

10. You must already be eligible for coverage at the time you make the regular self-payment; regular self-payments cannot be made to acquire initial eligibility or to re-establish eligibility.

11. The maximum self-pay period for active Employees is 9 months. However, an additional 1-month regular self-payment will be allowed on a limited basis when an Employee is Totally Disabled and the extra month is necessary to provide uninterrupted eligibility in the active Plan to qualify the Totally Disabled Employee for the Plan's -Short Term Disability Credited Hours program and for Weekly Disability Benefits effective on the first day of the 11th month.

12. If you are unable to work because you are disabled, you cannot make regular self-payments for the time you were disabled. Contact the Plan Office or your Local Union as soon as you are disabled so that you will be credited with disability hours. See the Eligibility During Disability section for more information about coverage during your disability.

13. You can authorize the Plan Office to automatically deduct any needed regular self-payments from your Special Fund account by submitting a completed authorization form to the Plan Office. Once your authorization is on file, the funds will automatically be transferred whenever your eligibility would otherwise terminate due to insufficient hours. Transfers will only be made if you have sufficient funds in your Special Fund account. No partial payments will be made from your account.

COBRA Coverage Self-Payments

This self-payment option is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended ("COBRA"). COBRA gives Qualified Beneficiaries the right to make self-payments for continued coverage under the Plan if coverage would otherwise be lost due to a Qualifying Event. This continued coverage is called "COBRA Continuation Coverage" or "COBRA coverage."

Eligibility for COBRA Coverage

Qualified Beneficiary

A Qualified Beneficiary under COBRA means an Employee or an Employee's Dependent covered by the Plan at the time of the Qualifying Event. A Qualified Beneficiary also includes a Child born to or placed for adoption with the Employee during the Employee's COBRA coverage period.

Qualifying Event

A Qualifying Event is an event that entitles a Qualified Beneficiary to elect COBRA Coverage. If you are a Covered Individual and an Employee, you have the right to elect COBRA Coverage if you lose coverage under the Plan due to one of the following Qualifying Events:

1. Your hours of employment are reduced; or

2. Your employment ends for any reason other than your gross misconduct.

A Dependent has the right to elect COBRA Coverage, if coverage under the Plan is lost due to one of the following Qualifying Events:

1. Your death;

2. Your hours of employment are reduced or your employment ends for reasons other than gross misconduct;

3. You become divorced or legally separated from your spouse; or

4. Your Dependent Child ceases to meet the Plan's definition of Dependent.

COBRA Coverage Notice and Election Procedures

The Plan has developed a notice and election procedure in accordance with COBRA as described below.

Notice to Plan Office

You or your Dependents are responsible for notifying the Plan Office, in writing, and providing documentation within 60 days of the date of a Qualifying Event that is a divorce, legal separation, or loss of Dependent status. Failure to notify the Plan Office within 60 days of the Qualifying Event causes a person to lose the opportunity to elect COBRA Coverage.

Your Employer is responsible for notifying the Plan Office if you lose coverage due to a reduction in hours, termination of employment or death. However, to ensure you receive information about your COBRA rights promptly, you or a family member should inform the Plan Office of any Qualifying Event.

If you do not notify the Plan Office on a timely basis, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan.

Contents of Notice

Your written notice should be given to the Plan Office at the address identified on page 146. The notice must include:

1. Your name, address and telephone number and the name, address and telephone number of your Dependents (if applicable);

2. The nature of the event (for example, divorce, loss of Dependent status, disability determination or the occurrence of a second Qualifying Event);

3. The date of the event.

If the Qualifying Event is a divorce or legal separation, you must also provide a copy of the decree of divorce or legal separation. If you cannot furnish this documentation within 60 days of the event, complete the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation within 30 days after the deadline. The notice will be deemed timely if you do so. However, no COBRA Continuation Coverage is available until this documentation is provided.

A notice that does not contain all of the required information will not be considered notice of a Qualifying Event or disability determination and may result in the loss of the right to elect COBRA coverage.

Electing COBRA Coverage

The Plan Office, within 30 days after receiving notice of a Qualifying Event, will send a Qualified Beneficiary a COBRA Election Notice and election form. The COBRA Election Notice contains complete instructions on how to elect COBRA Coverage. A COBRA Election Notice provided to a Qualified Beneficiary who is an Employee's spouse serves as notice to all other Qualified Beneficiaries living with the spouse at the time the notice is sent.

You have 60 days from the later of the date the Plan Office provided the COBRA Election Notice, or the date coverage terminates under the Plan to complete and return the election form to the Plan. If you do not return the form within 60 days, you will lose eligibility for COBRA Coverage.

Each Qualified Beneficiary generally has an individual right to elect COBRA Coverage. You may elect COBRA Coverage for yourself and for your Dependents. Your spouse may also elect COBRA Coverage for herself and for your Dependent Children. A Dependent Child age 18 and older may elect COBRA Coverage for himself or herself.

Unless otherwise specified, a COBRA Coverage election by an Employee (or former Employee) or an Employee's spouse will be deemed to include an election of COBRA Coverage for any other individual who would lose coverage because of the Qualifying Event.

In the event that the Plan Office determines that an individual is not entitled to COBRA Coverage, the Plan Office will provide to the individual an explanation as to why he or she is not entitled to COBRA Coverage.

COBRA Coverages

The following benefits are available under COBRA Coverage: medical benefits, prescription drug benefits, dental benefits, participation in the Special Fund and participation in the Vision Discount Program. COBRA Coverage does not include Weekly Disability Benefits, Death Benefits or AD&D Benefits.

If COBRA Coverage is elected, the benefits provided will be the same benefits that you or your Dependents were eligible before the day before the Qualifying Event.

Duration of COBRA Coverage

If you or your Dependents timely elect COBRA Coverage following a Qualifying Event that is your termination of employment (other than for gross misconduct) or a reduction in hours, coverage under the Plan can continue for up 18 months after the date of the Qualifying Event.

This 18-month period can be extended in the following situations:

1. Second Qualifying Event. A Dependent, as a Qualified Beneficiary, may experience more than one Qualifying Event. Your Dependents' COBRA Coverage may be extended up to a maximum period of 36 months if a second Qualifying Event that is your death, your divorce or legal separation from your spouse or your Child's loss of Dependent status occurs during this 18-month period. The combined continuation coverage period for all such Qualifying Events may not exceed 36 consecutive months from the date of the original Qualifying Event.

   You or your Dependents must notify the Plan in accordance with the notice procedures described above within 60 days after a second Qualifying Event during the initial 18-month period.

Note: Only a spouse or Child who was your Dependent on the day before the occurrence of the first Qualifying Event (termination or reduction in hours) or a Child born or placed with a covered Employee during a period of COBRA Coverage is entitled to make an election for this extended coverage when a second Qualifying Event occurs.

2. 11-month Extension for Disability. COBRA Coverage may be extended for 11 months, up to 29 months total, for you and your covered Dependents if you or any of the covered Dependents are determined by the Social Security Administration ("SSA") to have been disabled at any time during the first 60 days of the COBRA Coverage period and the disability lasts at least until the end of the 18-month period of the COBRA Coverage.

   To be eligible for this extension, you or your covered Dependents must, in accordance with the notice procedures described above, inform the Plan Office of the SSA determination within 60 days of the determination and before the end of the first 18 months of COBRA Coverage and provide a copy of the Social Security Disability Determination to the Plan Office.

   If the Qualified Beneficiary is determined by the SSA to be no longer be disabled, a Qualified Beneficiary must notify the Plan Office within 30 days of this determination.

Following a Qualifying Event that is your death, divorce or legal separation from you, or a Dependent Child ceasing to meet the definition of Dependent under the Plan, your Dependents may continue coverage for up to 36 months from the date of the Qualifying Event. When the Qualifying Event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months

before the Qualifying Event, COBRA Coverage for Qualified Beneficiaries other than you lasts until 36 months after the date of Medicare entitlement.

If you are entitled to Medicare at termination of employment, your covered Dependent spouse and Children will be eligible to continue COBRA coverage for a period of 36 months measured from the date of your Medicare entitlement, or 18 months measured from the termination of employment, whichever period is longer.

For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Coverage for his spouse and Dependent Children can last up to 36 months after the date of his Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months less 8 months).

Termination of COBRA Coverage

COBRA Coverage ends before the end of the applicable maximum period when:

1. The date the Plan no longer provides group health care coverage to any Eligible Employee;

2. The date coverage ceases because the Qualified Beneficiary failed to make a timely payment of the required COBRA self-payment;

3. The date, after electing COBRA Coverage, that the Qualified Beneficiary first becomes covered under any other group health Plan;

4. The date, after electing COBRA Coverage, a Qualified Beneficiary first becomes entitled to either Medicare Part A, Part B, or both (this termination date applies separately to each Qualified Beneficiary);

5. For a Qualified Beneficiary who was receiving the 11-month disability extension, the first day of the month beginning at least 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled; or

6. Fraud.

Payment for COBRA Coverage

The monthly COBRA self-payment amount is provided by the Plan Office on the COBRA election form. The cost of COBRA Coverage is determined by the Trustees based on the federal regulations. COBRA self-payments may be adjusted annually. If the rate changes while you are making self-payments, you must pay the new amount starting with the effective date of the new rate. There is an additional fee for Qualified Beneficiaries receiving the 11-month disability extension for continued COBRA Coverage from the 19th through the 29th month.

Once COBRA Coverage is elected, the initial COBRA self-payment must be made to the Plan Office not later than 45 days after the COBRA election form is mailed. The amount of the first COBRA self-payment is for the time period beginning with the date coverage would have terminated and extending through the month in which payment is made. Contact the Plan Office to determine the amount of the initial COBRA self-payment.

Subsequent monthly COBRA self-payments are due to the Plan Office on the first day of each month to continue coverage for that month. The Plan allows a 30-day grace period for making COBRA self-payments. If a payment is not received within 30 days of the due date, COBRA Coverage will be canceled and will not be reinstated.

NOTE: CLAIMS RECEIVED FOR EXPENSES INCURRED ON OR AFTER THE TERMINATION OF PLAN COVERAGE WILL NOT BE CONSIDERED FOR PAYMENT BY THE PLAN UNLESS THE APPLICABLE PAYMENTS ARE MADE ON TIME AS NOTED ABOVE.

Military Service

If you are a covered Employee on a leave of absence due to active military service, you may elect to continue coverage under this Plan. "Military service" means service in the uniformed services of the United States as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If you leave Covered Employment and enter military service for 31 days or more, coverage under the Plan for you and your covered Dependents will continue through the 30th day of your leave and will terminate on the 31st day of your leave. You can elect to continue coverage for yourself and your Dependents by making self-payments to the Plan, provided you and your Dependents are eligible for Plan coverage when your absence for military service begins.

The military's rules for coverage may vary from time to time and in different circumstances. In the event of your absence due to military service, contact the Plan Office to discuss the best option for you.

Continuation of Coverage Period

Under USERRA, the maximum coverage period will be the lesser of:

1. 24 months of continuous coverage beginning with the date your military leave of absence begins, or

2. the period of active military service plus time allowed to apply for reemployment under USERRA.

Election and Self-Payments

The Plan treats your election under USERRA the same as a COBRA election and COBRA and USERRA continuation coverage periods will run at the same time (concurrently). The procedures and periods used to elect to make self-payments for this continuation coverage are generally the same as those for COBRA Coverage, provided the COBRA rules do not conflict with USERRA. If you do not elect USERRA coverage in a timely manner and make all self-payments within the applicable timeframe, you lose the right to continue coverage under this provision and that right will not be reinstated. However, if there are differences between the USERRA rules and the COBRA rules, you and your Dependents will receive the benefit of the more generous rules.

If you have any accumulated Credited Hours when your leave for military service begins, you have the following options to pay for your continued coverage under the Plan:

1. You can use the accumulated Credited Hours to continue coverage after your absence to enter military service (provided you have enough hours to provide any continued coverage). After your hours have been exhausted, you may make self-payments until the end of the maximum coverage period that began with the date of your absence to perform military service.

2. You can freeze your accumulated Credited Hours and make self-payments to continue your Plan coverage. After your discharge from military service, your Credited Hours will be reinstated immediately provided you comply with the reemployment requirements of USERRA. If you do not comply with the USERRA reemployment requirements, your accumulated Credited Hours are forfeited.

You must notify the Plan of an absence due to military service in advance to be eligible to continue coverage under this provision. If you do not provide advance notice of your military service, your eligibility will terminate on the 31st day of your military leave (unless you can demonstrate your inability to provide notice in a timely manner that is satisfactory to the Trustees) and you will lose the right to continue coverage under this provision. Your right to continue coverage under this provision will not be reinstated unless the Trustees determine, in their sole discretion, that you were unable to provide notice in a timely manner.

If your Covered Employment is interrupted by military service that is less than 31 days, you will receive 40 Credited Hours for each week during which your military service is performed.

You must provide a copy of your military orders to the Plan Office in order to take advantage of any of the provisions described in this section.

Additional information about reemployment rights of persons returning to work from the uniformed services of the United States is available from the Veterans Employment and Training Administration of the United States (VETS).

These rules are intended to comply with the requirements of USERRA. The USERRA provisions will control in the event there are any inconsistencies between USERRA and the Plan.

Termination Upon Employer Withdrawal

A withdrawal occurs when an Employer's Collective Bargaining Agreement ceases to require contributions to the Plan for active Employees or when the Employer otherwise ceases to be required to make contributions to the Plan. A withdrawal can also occur when a Local Union negotiates health benefit coverage for a substantial number of its members under a Plan other than this Plan.

When a withdrawal occurs, persons having Plan coverage because of current or past employment with the Employer that has withdrawn will cease to be eligible for coverage under this Plan as of the date the Employer withdraws from the Plan. This includes active Employees, retired Employees, Employees (and Dependents) making self-payments, individuals on COBRA coverage (in certain circumstances), individuals maintaining coverage due to reciprocity, non-bargaining unit Employees of the affected Employers, Dependents, and Medicare Plus Blue Group PPO participants. Termination of eligibility also cancels all of an Employee's Credited Hours. Therefore, no extended eligibility otherwise available under the Plan because of Credited Hours will be available.

If the Employer maintains a group health Plan for Employees after withdrawing from the Plan, the Employer shall provide coverage under that group health Plan for its Employees, former Employees and their Dependents who are covered under this Plan or who are covered under this Plan's COBRA Coverage. That group health Plan must not exclude or limit treatment of preexisting conditions. The Employer will be considered the Plan sponsor and this Plan will have no responsibility for providing benefits for claims incurred after the date the Employer withdraws from the Plan.

Should the Plan be liable for benefits following the Employer's withdrawal, the Plan shall provide benefits only to the extent the Employer contributes to the Plan in an amount necessary to subsidize the coverage for these persons. The subsidy cost will be determined according to rules established by the Trustees.

If your Employer withdraws from this Plan as a Contributing Employer, contact the Plan Office immediately to see what effect, if any, the withdrawal will have on your and/or your Dependents' coverage under this Plan.

Termination and Reinstatement of Eligibility

Termination of Employee Coverage

You will cease to be eligible for Plan coverage on the first to occur of the following dates unless you make a regular self-payment or you are eligible for COBRA Coverage, and a correct and timely election and COBRA self-payment is made on your behalf:

1. The date of your death.

2. The date you enter the armed forces of any country (unless coverage is continued under the "Military Service" rules starting on page 20).

3. The date the Trustees discontinue this Plan.

4. The end of the last day of the coverage month corresponding to the last work month for which you met the Credited Hours requirement (under either the 135-hour or the rollback rules, or for a Non-Bargaining Unit Employee under the 160-hour rule).

5. If you are making regular self-payments and fail to make a correct and on-time payment, at the end of the last day of the last month for which you had previously earned or paid for coverage. Your coverage will also end after you reach the maximum number of self-payment months (generally nine).

6. If you are making COBRA self-payments, at the end of the last day of the last month for which you made a timely COBRA self-payment or on the date of occurrence of any event stated in "Duration of COBRA Coverage" on page 18, whichever occurs first.

7. If you are covered due to your current or past employment with a withdrawing Employer or group, the date on which the withdrawal occurs.

8. If you continue employment of any kind with a former Contributing Employer for whom you worked prior to such Employer withdrawing from the Plan, all Credited Hours (including Credited Hours for the roll-back rules) and benefits from the Plan are terminated and Special Fund account amounts are forfeited on the last day of the last month for which the Contributing Employer was required to contribute to the Plan. You are not eligible to make regular self-payments nor eligible to self-pay for the Early Disability and Retiree benefits after the date this eligibility is terminated, but you will retain your COBRA rights.

9. If you are employed with a non-Contributing Employer and perform work that would qualify as Covered Employment if it had been performed with a Contributing Employer within the jurisdiction of the Plan, all Credited Hours (including Credited Hours for the rollback rules) and benefits from the Plan are terminated and Special Fund account amounts are forfeited on the last day of the month in which such employment began or is discovered, whichever is earlier. You are not eligible to make regular self-payments nor eligible to self-pay for the Early Disability and Retiree benefits after the date this eligibility is terminated.

Reinstatement of Employee Eligibility

If your Credited Hours and benefits from the Plan were terminated and Special Fund account amounts were forfeited under the provisions of paragraphs 8 and 9 of the Termination of Eligibility subsection above and you return to Covered Employment within twelve (12) months of the date of the termination and forfeiture, your Credited Hours that were terminated will be reinstated effective as of the first day of the calendar month following the month in which the Plan Office receives contributions from a Contributing Employer on your behalf for at least 135 (or 160 for Non-Bargaining Unit Employees) Credited Hours in a one-month period. If your forfeited Special Fund account balance was $100 or more, your Special Fund account amounts will be reinstated if you return to Covered Employment with a Contributing Employer within 48 months of the date of the forfeiture and if your Special Fund account balance was less than $100 within 24 months of the date of the forfeiture.

Termination of Dependent Coverage

Your Dependent will cease to be eligible for Plan coverage on the first to occur of the following dates unless the Dependent is eligible for COBRA Coverage and a correct and timely election and COBRA self-payment is made on behalf of the Dependent:

1. The date the Trustees discontinue this Plan.

2. The date the Trustees terminate coverage for Dependents under this Plan.

3. The date you cease to be eligible for Plan coverage for reasons other than your death.

4. For your spouse, on the end of the month in which the divorce or legal separation under a decree of separate maintenance.

5. For a Dependent Child, the date the Child ceases to meet the Plan's definition of a Dependent.

6. If COBRA self-payments are being made on behalf of the Dependent, at the end of the last day of the last month for which a correct and on-time self-payment was made or on the date of occurrence of any event stated in "Duration of COBRA Coverage" on page 18, whichever occurs first.

7. In the event of your death, at the end of the last day of the last month for which you had earned or paid for eligibility before your death, unless a self-payment for COBRA Coverage or the Surviving Dependents Program is made by or on behalf of the Dependent.

8. If a surviving Dependent's coverage is being continued through self-payments under the Surviving Dependents Program (starting on page 37) and a correct and on-time self-payment is not made, at the end of the last day of the last month for which a correct and on-time self-payment was made;

9. For a surviving spouse and Dependent Children, the date on which the spouse remarries.'

Retroactive Recission of Coverage

The Plan will not rescind health coverage under the Plan with respect to an Eligible Employee, Eligible Retiree or Eligible Dependent once the individual is covered under the Plan, unless the individual (or the Eligible Employee or Eligible Retiree in the case of an Eligible Dependent) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan, and in other instances that may be prescribed in the Treasury Regulations. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is attributable to a delay in administrative recordkeeping if the Eligible Employee, Eligible Retiree or Eligible Dependent does not make any Self Payments when due. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required Self Payments toward the cost of coverage. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the last day of month in which the date of divorce occurs.

The Plan is required to provide at least 30 days advance written notice to each individual who is affected by a rescinding of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group. A rescission is also a type of adverse benefit determination of a health plan claim as defined under the U.S. Department of Labor Regulations.

Early Eligibility Program

Newly Organized Employees

If you are an individual Employee who has been newly organized (or an Employee of a newly organized Employer), you may be entitled to make self-payments for early eligibility, while you work to meet the regular initial eligibility rules, pursuant to the following rules:

1. You cannot self-pay for coverage for the month in which you start work. For example, if you first begin Covered Employment in August, you can self-pay for September coverage, but not August coverage.

2. Self-payments for the first month of early eligibility will be set by the Board of Trustees. Effective January 1, 2024, this rate was $400. If the newly organized Employee works less than 135 hours in their initial month of employment, the self-payment for the second month of coverage will equal 135 hours multiplied by the self-pay rate in effect for the classification in which the Employee works and reduced by contributions paid.

3. You can make up to two consecutive self-payments for early eligibility. After that, you must establish eligibility through work hours.

4. The early coverage provided for you and any covered Dependents will be all of the Plan's normal benefits.

5. Your continuing eligibility will be governed by the normal rules for Bargaining Unit Employees (*e.g.*, the 135-hour rule, the rollback rule, and the regular self-payment rule after you satisfy initial eligibility).

6. You are not required to make the self-payment to obtain eligibility for the month immediately following the month in which you start work. However, you can only elect coverage on a prospective basis. For example, if you work in January without making a self-payment to obtain early eligibility for February and are then laid off until you work again in April, you can elect to make your self-payment to obtain coverage for May. Your January and April work hours will be combined for purposes of satisfying the 135-hour initial eligibility requirement.

7. If you do not become eligible under the Plan's regular eligibility rules at the end of the allowable period of coverage under these rules, you may be entitled to elect to make COBRA self-payments for continued Plan coverage according to the rules governing COBRA Coverage.

8. If you are covered due to your current or past employment with a withdrawing Employer or group, your coverage will terminate on the date the withdrawal occurs.

New Non-Bargaining Unit Employees

If you are a new Non-Bargaining Unit Employee, you can make up to two consecutive monthly self-payments for early eligibility for yourself and your Dependents. The rules governing your early eligibility are the same as the rules for newly organized Employees (described above), except that your self-payment for the second month must be at the rate of 160 hours per month times the current base contribution rate. After you make two consecutive self-payments, the rules for all other Non-Bargaining Unit Employees will apply.

Apprentices

If you are a new apprentice entering a training program arranged by the JATC, you may make self-payments for early eligibility. The rules governing your early eligibility are the same as the rules for newly organized Employees.

Cable Pullers and Residential & Motor Shop Trainees

If you are a new cable puller or a residential or motor shop industry trainee and your Employer's Collective Bargaining Agreement has a provision for such a classification and your Employer makes the required contributions to the Plan, you may be able to self-pay for early eligibility.

The rules governing your early eligibility are the same as the rules for newly organized Employees. In addition, the following rules will also apply:

1. If you become a cable puller more than six months after beginning Covered Employment in the electrical industry, you cannot self-pay for early eligibility. Similarly, if you enter a training program more than six months after beginning Covered Employment in the electrical industry, even if the program is an approved residential or motor shop training program, you will not be considered a trainee under the Plan and cannot self-pay for early eligibility.

2. If you cease to be a cable puller or cease to participate in the training program, or if you do not become eligible under the Plan's regular eligibility rules by the end of your allowable early eligibility period, you may be entitled to elect to make COBRA self-payments for continued Plan coverage according to the rules governing COBRA Coverage.

3. Your coverage under these early eligibility rules will terminate if you cease to be a cable puller or cease to participate in the training program.

Eligibility If You Become Disabled (Eligibility During Disability)

Short-Term Disability

If you become Totally Disabled either on the job or off the job, you will be credited with disability hours during the period during which you are Totally Disabled according to the rules below.

For the exclusive purpose of crediting disability hours, Totally Disabled (or Total Disability) means your complete inability, as a result of a work-related or non-work-related, accidental bodily injury or sickness to perform any and every duty of your occupation or employment.

Short-Term Disability Hours Rules

1. You must provide the Plan Office with acceptable medical proof that you are Totally Disabled. If you fail to supply such proof within 12 months of the date you become Totally Disabled, your application for disability hours will be denied unless the exception described in paragraph 2 applies.

2. If you are Totally Disabled and you obtain a Social Security Disability Income award, you may apply for disability hours under the Plan within 6 months of the date of such award, provided you have remained continuously eligible under the Plan through rollback hours or regular self-payments.

3. You will be credited with 8 hours for each full day of Total Disability that falls on a normal work day of the week except Saturdays and Sundays, starting with your first full day of Total Disability. No hours are credited for partial days.

4. The disability hours will be used as regular Credited Hours in determining your eligibility under the 135-hour rule, but they will NOT be counted under the rollback rule.

5. You can be credited with up to a maximum of 160 disability hours during a month, and you can receive disability hours for up to 24 months for the same or related disability.

6. If, while receiving disability hours, you take normal or early retirement (other than due to disability) before you have received the 24 months of disability hours, you will not be credited with any further disability hours.

7. If you become Totally Disabled after satisfying the initial eligibility requirements but before your Initial Eligibility Date, you will be credited with disability hours beginning with your Initial Eligibility Date.

8. You cannot use disability hours to gain initial eligibility or to re-establish eligibility if your eligibility terminates.

9. If you are an apprentice, you will cease to be eligible for disability benefit hours on the date you cease to participate in an apprenticeship program.

For information on the Weekly Disability Income Benefit (Loss-of-Time Benefit), see page 26.

Long-Term Disability

If you are Totally Disabled and have received 24 months of coverage under the Short-Term Disability rules but do not qualify for Early and Disability Retiree Benefits, you can make self-payments to continue medical and prescription drug coverage for you and your Dependents according to the rules below.

Long-Term Disability Self-Payment Rules

1. Your monthly self-payment amount will be 160 times 100% of the current base Employer contribution rate.

2. Your monthly self-payments are due on or before the first day of the month for which you are paying. If you fail to maintain continuous and uninterrupted coverage by making on-time payments, you will not be allowed to make any further self-payments.

3. You can make these self-payments until you are no longer Totally Disabled or until you qualify for Early and Disability Retiree Benefits or Medicare. Proof of your disability must be submitted with each monthly self-payment.

4. If you return to active work and become Totally Disabled while eligible due to the same or related disability, you will not qualify for 24 months of disability hours, but you may start self-paying again under these rules at the 100% rate.

5. If you die while making self-payments under this provision, your spouse can make self-payments under the same rules that apply to surviving spouses under the Surviving Dependents Program (see page 36). If you are an Employee whose disability onset date (as determined by the SSA) is within 24 months of the date you exhausted eligibility under the 24-month period described above and you maintain creditable coverage through your spouse's health Plan continuously from the date your eligibility was exhausted, you will qualify for Early and Disability Retiree coverage or Medicare coverage (if applicable) effective the first day of the month following completion of the five-month Social Security elimination period.

Weekly Disability Benefit (Loss-of-Time Benefit)

Only active Eligible Employees are eligible for Weekly Disability Benefits. Retirees, Dependents and any COBRA Qualified Beneficiaries are not eligible to receive this benefit.

Eligibility for Weekly Disability Benefits

In order to be eligible for Weekly Disability Benefits, you must be eligible from working or from making regular self-payments up to the date your disability starts (your eligibility cannot have been earned from using disability hours). Also, you must make, or continue to make, any self-payments which are billed by the Plan Office. If, after you start receiving weekly benefits, the Plan Office determines that you were not actually eligible from working or making regular self-payments when your disability started, you will be required to repay the Plan the amount of the weekly benefits the Plan has already paid to you. If you are an apprentice, you will cease to be eligible for disability benefits on the date you cease to participate in an apprenticeship program.

Definition of Total Disability

The definition of Total Disability (or Totally Disabled), as applied to this benefit, means your complete inability to perform any and every duty of your occupation or employment as a result of non-occupational accidental bodily injury or sickness.

Your disability must be certified by a Doctor (M.D. or D.O.). If the Doctor who certifies your disability is a chiropractor (D.C.), you must have the disability certified after 4 weeks by a medical Doctor.

Note About Occupational Disabilities: If your disability is occupational, you are NOT eligible to receive Weekly Disability Benefits, but you must notify the Plan Office so that you will be credited with disability hours. If you receive Weekly Disability Benefits for a disability and then later receive Workers' Compensation benefits for that same disability, you will be required to reimburse the Plan for the weekly benefits you received from the Plan.

When Benefits Start

Regardless of the following rules, a disability will not be considered to have started until the day you are examined by a Doctor and the Doctor certified your disability.

Benefits will start on the first day of Total Disability due to an accidental injury, provided the Total Disability begins within one week from the date of the accident.

Benefits will start on the 8th day of Total Disability due to sickness. However, if your sickness lasts for 8 days or more, you will receive a retroactive disability benefit payment for the first 7 days of the sickness. (Disabilities due to pregnancy, pregnancy-related conditions and maternity are paid as disabilities due to sickness.)

If you become disabled after working enough hours to satisfy the initial eligibility rules but before actually becoming eligible, your Weekly Disability Benefits will begin on the first day (for injury) or 8th day (for sickness) after you become eligible.

In no event will weekly benefits start before your initial eligibility date. Also, if you are receiving unemployment benefits, your weekly benefits will not start until your unemployment benefits are discontinued.

Amount of Benefit

The amount of your weekly benefit is the lesser of $400 or 60% of your 40-hour-per-week wage. Benefits are based on a 5-day work week (excluding Saturdays and Sundays). If benefits are due to you for a part of a week, you will receive one-fifth of the weekly benefit for each day of Total Disability.

Length of Benefit Period

If you become Totally Disabled and unable to work as a result of non-occupational accidental injury or sickness while you are eligible for this benefit, weekly benefits are payable for up to 52 continuous weeks during one period of disability.

However, if you receive weekly benefits for more than 26 weeks and if you qualify for Social Security Disability Income, you will be required to reimburse the Plan for any disability payments you received from the Plan after the first 26 weeks for which you also received a Social Security disability payment.

Concurrent Periods of Disability

More than one disability occurring or existing at the same time will be considered one continuous period of disability. Benefits payable will be limited to a maximum of 52 weeks.

Sporadic Periods of Disability

Sporadic periods of disability (disabilities happening from time to time) resulting from the same or related causes will be considered one continuous period of disability even if you return to work between the periods of disability. Benefits payable will be limited to a maximum of 52 weeks.

Second Period of Disability

If a second period of disability is due to an injury or sickness entirely unrelated to the cause of the first disability, then the second disability will begin a new period of disability as long as you are given a medical release from the certifying Doctor (M.D. or D.O.) for the first disability.

If you become Totally Disabled due to a non-work related accidental injury or sickness for which you have previously received the maximum of 52 weeks of Weekly Disability Benefits from the Plan, you can become eligible for Weekly Disability Benefits from the Plan for a period of disability for the same cause as that first period provided that you have returned to active Covered Employment for a period of 6 consecutive months or more. This second absence from work will be treated as a new period of disability. This second period of disability is subject to the same requirements for proof of Total Disability and reporting as the prior period of disability.

Taxation of Weekly Disability Benefits

You must include your Weekly Disability Benefits in your gross income and pay federal income tax on them. The Plan Office will send you a W-2 Form to use for this purpose. If you have a question about including Weekly Disability Benefits in your gross income or about exclusions in the law, check with a competent tax advisor or counsel.

Your Weekly Disability Benefits are also subject to Social Security Taxes (FICA). In accordance with federal law, the Plan will withhold your share of the FICA tax from each weekly benefit payment (up to a maximum of 6 months) and will send it to the government.

Exclusions and Limitations

No Weekly Disability Benefits will be paid:

1. For any disability resulting from occupational accidental injury or sickness or occurring while performing service in the uniformed services of any country;

2. For any disability resulting from sickness or injury for which you are not under the direct and continuous care of a Doctor (M.D. or D.O.) (this means that you are examined by a Doctor at least once every 3 months);

3. After the first 26 weeks of benefits, for any period during which you are eligible for Social Security Disability Income; or

4. For any disability which exists beyond the date you retire (unless you qualify for Early and Disability Retiree Benefits), or which starts after you retire.

Eligibility When You Retire

Qualifying For Retiree Benefits

There are three ways in which retired Employees may qualify to receive benefits under the Plan.

Early and Disability (E&D) Retiree Benefits

If you are not eligible for Medicare, you may be entitled to make self-payments for Early and Disability (E&D) Retiree Benefits.

Medicare Eligible Retirees

If you are eligible for Medicare, you may be entitled to make self-payments for the Medicare Plus Blue Group PPO Medical Program.

COBRA Coverage

Retirement is a COBRA Qualifying Event. If you are eligible for Plan benefits as an active Employee when you retire, you may make self-payments for up to 18 months for continued coverage for you and your covered Dependents under the COBRA Coverage rules.

Medicare entitlement is a terminating event under COBRA. A person who is not eligible for Medicare when he elects COBRA Coverage but who later becomes eligible for Medicare will lose the right to make any additional COBRA self-payments.

After you retire, you can make COBRA self-payments for a period and switch to the E&D Retiree Benefits if you satisfy all of the following requirements:

1. You were eligible for at least 36 months during the 60 months immediately preceding your retirement date as a result of active employment or on account of disability, layoff or unemployment before your COBRA Coverage became effective (see Eligibility Requirements for E&D Retiree Benefits" on page 29).

2. You maintain continuous COBRA Coverage, and enroll in the E&D Retiree Benefits program before the end of your 18-month COBRA period; and

3. Your Retiree coverage immediately follows your COBRA Coverage with no interruption in coverage (There can be no gap between your COBRA Coverage and the start of your E&D Retiree Benefits).

If you elect coverage under the Plan's E&D Retiree Benefits or the Medicare Plus Blue Group PPO Program, you are rejecting your right to elect COBRA Coverage and CANNOT elect it in the future.

Benefits for Retirees are Not Accrued or Vested

Retiree coverage is not an accrued or vested benefit.

The Trustees may reduce the coverage, initiate or increase self-payments for the coverage, or eliminate the coverage in their sole discretion.

Important Limitations

No Regular Self-Payments After Retirement

Once you start receiving a pension, you are not entitled to make regular self-payments for coverage as an active Employee under the Plan unless you earn sufficient Credited Hours and requalify as an Eligible Employee. In order to receive benefits under the Plan, you must either make COBRA self-payments or enroll for coverage under the E&D Retiree Benefits or the Medicare Plus Blue Group PPO Medical Program.

Termination Upon Employer Withdrawal

If you are covered under any of the Retiree benefits provided under the Plan and your former Employer withdraws from participation as a Contributing Employer to this Plan, the Employer's withdrawal may have an effect on your benefit coverage. If you know that your Employer has withdrawn from participation in the Plan, contact the Plan Office immediately to find out if your coverage under this Plan will be affected by the Employer's withdrawal. (For more information see "Termination Upon Employer Withdrawal" on page 21.)

Early Disability and Retiree Benefits

Eligibility Requirements for E&D Retiree Benefits

You will be eligible for E&D Retiree Benefits provided you have not lost eligibility on account of the Plan's provisions on continuing employment of any kind with a former Contributing Employer for whom you worked prior to such Employer withdrawing from the Plan or if you are employed with a non-Contributing Employer and perform work that would qualify as Covered Employment if it had been performed with a Contributing Employer within the jurisdiction of the Plan (described in paragraphs 7 and 8 on page 16) and you meet all of the following requirements:

1. You are not currently eligible to receive benefits under Medicare (except if you are eligible for Medicare benefits solely as an End Stage Renal Disease beneficiary you may be covered during the period which the Plan is required to pay Primary to Medicare under the Medicare secondary payer rules);

2. You were eligible to receive benefits under either the basic 135-rule or the rollback rule as a result of active employment or on account of disability, layoff, or unemployment (but not COBRA Coverage) for at least 3 years (36 months) out of the 5 years (60 months) immediately preceding your retirement date. Your Retiree coverage must immediately follow, with no interruption in coverage, unless you elect and maintain uninterrupted COBRA Coverage following your retirement and you enroll in E&D Retiree Benefits during the 18-month COBRA Coverage period having satisfied the 3 years out 5 years requirement before your COBRA Coverage become effective;

3. You provide written proof that you satisfy one of the following three retirement requirements:

   - You are retired under the early retirement provisions of an industry-sponsored pension Plan;
   - You are retired under the disability provisions of the Social Security program, or you meet other disability requirements established by the Trustees; or
   - You are a retired Non-Bargaining Unit Employee who is at least age 55, you meet the service requirements and all other requirements for E&D Retiree Benefits, except for qualifying for an industry-sponsored pension Plan, and have left all employment including clerical or management work, for any Employer in the industries covered by the Plan; and

4. You have enrolled and made the proper Retiree self-payments to the Plan.

If you receive and provide the Plan with a copy of a SSA disability award retroactive to a disability onset date preceding or coincident with the date of your eligibility for Plan benefits as an active Employee terminated, you may enroll for E&D Retiree Benefits retroactive to the date your eligibility as an active Employee terminated, provided you pay the amount of monthly self-payments for retroactive periods. Further, if you satisfy this requirement and had earlier enrolled in the early Retiree Benefit program, you can retroactively convert your early Retiree Benefit to a disability Retiree Benefit provided no more than three years have elapsed following the date your eligibility as an active Employee terminated.

Dependent Eligibility

If you are covered under the E&D Retiree Benefits, your Dependents will also be eligible for E&D Retiree Benefits. If your spouse becomes eligible for Medicare before you do, your spouse will become covered under the Medicare Plus Blue Group PPO Program.

If you acquire a new Dependent, you should notify the Plan Office within 30 days.

Spouse Plan

If you are eligible for the Medicare Plus Blue Group PPO Program, your Dependents who are not eligible for Medicare will be eligible for E&D Retiree Benefits. Your spouse (and any Dependent Children) will be considered covered under the "spouse Plan," which requires your spouse to file claims for himself or herself and any Children under your spouse's name and Social Security number instead of under yours. Your spouse's first self-payment under the spouse Plan is due before your spouse's coverage would otherwise terminate. Additional information about the spouse Plan is available from the Plan Office.

Enrollment for E&D Retiree Benefits

If you are under age 65 and plan to retire, or if you are retiring because of disability and are not yet eligible for Medicare, you must contact the Plan Office to enroll and make the required self-payments.

Your enrollment must be made before your coverage under the Plan as a regular active Employee terminates, unless you elect and maintain COBRA Coverage as described in paragraph 2 of "Eligibility Requirements for E&D Retiree Benefits" above. If you are covered under another Plan when you retire, such as your spouse's Plan, you must still enroll while you are eligible for the regular active Employee benefits if there is any possibility that you might want the E&D Retiree Benefits in the future.

Retiree and Dependent Opt-Out Rules

If you are a Retiree or Dependent spouse eligible for E&D Retiree coverage, you may elect on a one-time basis to opt out of coverage under this Plan if you:

1. Enroll in other Employer-provided group health Plan coverage;

2. Complete, sign and return to the Plan Office the Coverage Opt-Out Form acknowledging the request to opt out of coverage under this Plan and its Special Fund while enrolled in other group health Plan coverage; and

3. Submit proof that you are enrolled under another Employer-provided group health Plan.

Completing and submitting the Opt-Out Form is strongly encouraged. However, if a Retiree or Dependent Spouse inadvertently fails to take this step, they can still qualify for Opt-In rights provided they satisfy the other requirements.

Coverage under this Plan (including the Special Fund) for a Retiree or Dependent spouse opting out will terminate at the end of the last day of the month during which a completed and signed Coverage Opt-Out Form is received by the Plan Office.

The opt out election will remain in effect until the Retiree or Dependent spouse requests reenrollment and is re-enrolled in coverage under the E&D Retiree Plan under the opt-in rules below and provides written evidence satisfactory to the Plan of maintaining continuous uninterrupted coverage under another group health Plan.

If a Retiree or Dependent spouse elects to opt out of E&D Retiree coverage under this Plan, no Special Fund reimbursements will be made for any health care expenses incurred on or after the date the Coverage Opt-Out Form is signed, even if such health care expense would qualify as a reimbursable expense under the Special Fund.

Retiree or Dependent Opt-In Rules

A Retiree or Dependent spouse who has opted out of E&D Retiree coverage in accordance with the provisions above, may later reinstate Plan coverage provided all of the following requirements are satisfied:

1. Coverage under the alternate group health Plan has terminated or is terminating; and

2. Satisfactory written proof of continuous, uninterrupted group health Plan coverage is provided starting from the opt-out effective date.

Coverage under this Plan will be effective on the first day of the month following the date a completed and signed opt in form and satisfactory proof of continuous group coverage under the other group health Plan are received by the Plan Office.

Benefits will not be covered under the Plan for any health care expenses incurred prior to the effective date of re-enrollment in E&D Retiree coverage.

Self-Payments for E&D Retiree Benefits

Self-payment rates are determined by the Trustees based on the cost of the coverage and can be changed at any time. The amount of your monthly self-payment is based on your age in the month (effective June 1, 2024, based on your age and Years of Service) for which the payment is made, and is the same whether or not you have a spouse or Child. However, if your spouse becomes covered under the Medicare Plus Blue Group PPO Program before you do, you will pay the Medicare Plus Blue Group PPO Program rate for your spouse, and a reduced single-coverage E&D Retiree Benefits rate for yourself. When you contact the Plan Office to enroll for E&D Retiree Benefits, you will be told how much the monthly payments will be and you will be given the forms for sending in your payments. You will also be sent an acknowledgment each time a payment is received.

Note: There is a special reduced self-payment rate for Employees who retire due to disability. The disability rate applies only to Retirees who are disabled at the time they retire, not to Retirees who obtain a Social Security disability award after they start receiving E&D Retiree Benefits unless they receive their Social Security award no later than three years after terminating coverage as an active Employee (described on page 28).

In addition, a special payment option is available to a Retiree and a Retiree's Dependent spouse who are both under age 65 and eligible for Medicare because they are Social Security Disability beneficiaries. If you and your Dependent spouse are eligible for the special payment option, you can continue coverage under the Plan's Medicare Plus Blue Group PPO Program by paying the lower of: (a) the self-payment rate for E&D Retiree benefits, or (b) the self-payment rate for the Medicare Plus Blue Group PPO Plan.

You can have the payments automatically deducted from your pension check. In order to do this, you must complete an authorization form provided by the Plan Office. You can also make your payments by check or money order. Your payment, along with the correct form, must be received by the Plan Office no later than the 15th day of the month for which you are paying. Make your check or money order payable to the Michigan Electrical Employees' Health Plan. You will not have eligibility until the payment for that month is received.

You can make up to 6 months of payments in advance. In the event of your death, any remaining advance self-payments will be applied to purchase future coverage for your Spouse, if applicable, or reimbursed to your estate.

If you fail to make the correct payment by the date it is due, coverage for you and your Dependents will terminate at the end of the period for which you already made payments and no further self-payments will be allowed.

E&D Retiree Benefits Payable

If you meet the eligibility requirements, you and your Dependents will continue to be eligible for the same medical and prescription drug coverage you had under the Plan as an active Employee. You will NOT be eligible for Weekly Disability Benefits (Weekly Disability Benefits and disability hours stop on the date you retire).

Termination of Retiree Coverage

You will cease to be eligible for E&D Retiree Benefit coverage on the first to occur of the following dates:

1. The first day of the month during which you become entitled to Medicare.

2. The date the Trustees discontinue E&D Retiree Benefits.

3. The date the Trustees discontinue the Plan.

4. The date of your death.

5. If you are a Retiree who retired from Non-Bargaining Unit employment, the date you return to work, including clerical or management work, for an Employer in the industries covered by the Plan.

6. If you fail to make a correct and on time self-payment, the end of the last day of the last month for which a correct and on time self-payment was made.

Termination of Dependent Coverage

A Dependent of yours will cease to be eligible for E&D Retiree Benefit coverage on the first to occur of the following dates:

1. The date the Trustees discontinue the Plan.

2. The date the Trustees discontinue E&D Retiree Benefits or discontinue Dependent coverage under the E&D Retiree Benefits.

3. If a correct and on-time payment fails to be made to the Plan by or on behalf of the Dependent to maintain coverage, the end of the last day of the last month for which a correct and on-time payment was made.

4. If you are a Retiree who retired from non-bargaining work, the date you cease to be eligible for E&D Retiree Benefits because of your return to work for an Employer in the industries covered by the Plan.

5. For a Dependent Child, the date the Child loses Dependent status, unless the Child is entitled to COBRA Coverage, an on-time COBRA self-payment is made by or on behalf of the Child.

6. For a Dependent spouse, the date of your divorce or legal separation under a decree of separate maintenance, unless the spouse is entitled to COBRA Coverage, an on-time COBRA Coverage self-payment is made by the spouse.

7. For a Dependent spouse if you are paying for E&D Retiree Benefits for your Dependents after you become eligible for Medicare, on the first day of the month during which the spouse becomes eligible for Medicare.

8. In the event of your death:

    - On the first day of the month following the month for which self-payments had been paid in advance (unless a self-payment is made for E&D Retiree Benefits under the Surviving Dependents Program or COBRA);
    - For a Dependent spouse who is eligible for Medicare on the date of your death, on the first day of the month following the month in which you die; and
    - For Dependents whose E&D Retiree Benefits are being continued through self-payments under the Surviving Dependents Program:

- If a correct and on-time payment is not made by or on behalf of the Dependent, the end of the last day of the last month for which a correct and on-time payment was made;
- For a Dependent Child, the date the Child loses Dependent status;
- For a surviving spouse or Child who is not eligible for Medicare on the date of your death, the date on which the spouse or Child becomes eligible for Medicare; or
- For a surviving spouse and the spouse's Dependent Children, if any, the date the spouse remarries.

When You Become Eligible for Medicare

When you become eligible for Medicare, you are no longer eligible for E&D Retiree Benefits. (You will, though, be eligible for the Medicare Plus Blue Group PPO Program.)

You can continue to make self-payments for E&D Retiree Benefits coverage for any of your Dependents (spouse and Dependent Children) who are not eligible for Medicare. Your non-Medicare-eligible spouse (and any Dependent Children) will be considered covered under the E&D Retiree Benefits "spouse Plan" (see page 30).

You can stop making the payments for your Dependents at any time, and their coverage will terminate at the end of the period for which you have already paid. After that time, their coverage cannot be reinstated. If you stop making the payments, your spouse will still be eligible for the Medicare Plus Blue Group PPO Program when your spouse reaches age 65, enrolls in both Part A and Part B of Medicare, and the proper self-payments are made on your spouse's behalf.

Retirees With End Stage Renal Disease (ESRD)

If you are eligible for Medicare due solely to End Stage Renal Disease ("ESRD"), you will be covered under the E&D Retiree Benefits program during the 30-month period that group health Plans are required to pay primary over Medicare. During this 30-month period, the required self-payment will be the same as the amount required for coverage under the Medicare Plus Blue Group PPO Program.

When Your Spouse Becomes Eligible for Medicare

When your spouse (or Dependent) becomes eligible for Medicare, E&D Retiree Benefits coverage will terminate, and your spouse will become eligible for the Medicare Plus Blue Group PPO Program. He or she must be enrolled in both Part A and Part B of Medicare. If a Dependent who is entitled to Medicare is NOT enrolled in Medicare Part A and Part B that Dependent's coverage will terminate.

Even if both you and your spouse are covered under the Medicare Plus Blue Group PPO Program, you can continue to make payments to cover your Dependent Children under the E&D Retiree Benefits.

Enroll in Medicare Before Your 65th Birthday

If you are eligible for E&D Retiree Benefits but will soon be eligible for Medicare, contact your local Social Security office (before you reach age 65) to find out how to enroll for Medicare Part A and Part B. This also applies to any Dependent who will soon be eligible for Medicare.

Except as described above for Retirees with ESRD, you can be eligible for the E&D Retiree Benefits only as long as you are not eligible for Medicare. Once you become eligible for Medicare, you are eligible ONLY for the Medicare Plus Blue Group PPO Program. The same rule applies to your Eligible Dependents.

Medicare Plus Blue Group PPO Program

The Plan provides benefits for Medicare-Eligible Retirees and Retiree's Medicare-Eligible Dependents who satisfy the eligibility requirements below under a group Medicare Advantage Preferred Provider Program ("MAP") administered by BCBSM. This program is called Medicare Plus Blue Group PPO and it is described in separate Benefit Component documents.

Retiree Eligibility

You will be eligible for coverage under the Medicare Plus Blue Group PPO Program if you meet the following requirements:

1. You must be enrolled for both Part A and Part B of Medicare;

2. You must have been eligible to receive benefits under the Plan as an active Employee as a result of active employment or on account of disability, layoff, or unemployment (but not COBRA Coverage) on the day before your Retiree coverage begins, and for at least 3 years (36 months) out of the 5 years (60 months) immediately preceding the date of your retirement; and

3. You must make correct and on-time self-payments for the coverage.

Dependent Eligibility

A Dependent (spouse or Child) will be eligible for the Medicare Plus Blue Group PPO Program if the following requirements are met:

1. You (the Retiree) must be an Eligible Retiree covered under the E&D Retiree Benefits or the Medicare Plus Blue Group PPO Program;

2. The Dependent must be eligible for and enrolled in both Part A and Part B of Medicare; and

3. You must make correct and on-time self-payments for the coverage.

Previous E&D Retiree Coverage Not Required

You do not have to participate in the E&D Retiree Benefits program in order to be eligible for the Medicare Plus Blue Group PPO Program when you become eligible for Medicare. However, you must contact the Plan Office before your 65th birthday if you want to enroll in the Medicare Plus Blue Group PPO Program.

Retiree and Dependent Opt-Out Rules

If you are a Retiree or Dependent spouse eligible for the Medicare Plus Blue Group PPO Program or Retiree benefits, you may elect on a one-time basis to opt out of coverage under this Plan if you:

1. Enroll in another Employer-provided group health Plan, individual health Plan or Medi-gap health Plan coverage;

2. Complete and sign the Coverage Opt-Out Form acknowledging the request to opt out of coverage under this Plan and its Special Fund while enrolled in other group health Plan coverage; and

3. Submit proof that you are enrolled under another Employer-provided group health Plan, individual health Plan or Medi-gap health Plan.

Coverage under this Plan (including the Special Fund) for a Retiree or Dependent spouse opting out will terminate at the end of the last day of the month during which a completed and signed Coverage Opt-Out Form is received by the Plan Office.

The opt out election will remain in effect until the Retiree or Dependent spouse requests reenrollment and is re-enrolled in coverage under the Plan under the Opt-In Rules below and provides written evidence satisfactory to the Plan of maintaining continuous uninterrupted coverage under another group, individual or Medi-gap health Plan.

If a Retiree or Dependent spouse elects to opt out of coverage under this Plan, no Special Fund reimbursements will be made for any health care expenses incurred on or after the date the Coverage Opt-Out Form is signed, even if such health care expense would qualify as a reimbursable expense under the Special Fund.

Retiree or Dependent Opt-In Rules

A Retiree or Dependent spouse who has opted out of coverage in accordance with the provisions above, may later reinstate Plan coverage provided all of the following requirements are satisfied:

1. Coverage under the alternate health Plan has terminated or is terminating; and

2. Satisfactory written proof of continuous, uninterrupted group, individual or Medi-gap health Plan coverage is provided starting from the opt-out effective date.

Coverage under this Plan will be effective on the first day of the month following the date a completed and signed opt in form and satisfactory proof of continuous coverage under the other group, individual or Medi-gap health Plan are received by the Plan Office.

Benefits will not be covered under the Plan for any health care expenses incurred prior to the effective date of re-enrollment in Plan coverage.

Benefits Provided

If you meet the eligibility requirements stated above and make any required self-payments, you will be eligible for the Medicare Plus Blue Group PPO Program.

Adding a Dependent

If you marry, you must notify the Plan Office within 30 days of the date of the marriage, so that you can begin making any necessary self-payments on a timely basis. If you do not enroll your new spouse in the Plan's Medicare Plus Blue Group PPO Program at that time, you cannot later add your spouse to your coverage.

Self-Payments for the Medicare Plus Blue Group PPO Program

Self-payments are required for each person. The amount of the self-payment is determined by the Trustees and may be changed at any time. You can have the payments automatically deducted from your pension check. In order to do this, you must complete an authorization form provided by the Plan Office. You can also choose to make the monthly payments by check or money order. Payment is due on the first day of the month for which coverage is desired.

> **Note:** See page 31 for the special self-payment option Retirees and their Dependents under age 65 who are eligible for Medicare due to Social Security Disability.

Termination of Retiree Coverage

You will cease to be eligible for the Medicare Plus Blue Group PPO Program on the first to occur of the following dates:

1. The date the Trustees discontinue the Medicare Plus Blue Group PPO Program.

2. The date the Trustees discontinue the Plan.

3. The date of your death.

4. If you fail to make a correct self-payment by the first day of the first month for which the payment is billed, the end of the last day of the last month for which a correct and on time self-payment was made.

Termination of Dependent Coverage

A Dependent of yours will cease to be eligible for the Medicare Plus Blue Group PPO Program on the first to occur of the following dates:

1. The date the Trustees discontinue the Plan.

2. The date the Trustees discontinue the Medicare Plus Blue Group PPO Program.

3. The date the Trustees discontinue coverage for Dependents under the Medicare Plus Blue Group PPO Program.

4. If you fail to make a correct self-payment by the first day of the first month for which the payment is billed, the end of the last day of the last month for which a correct and on time self-payment was made.

5. The date of your divorce or legal separation from your spouse.

6. If a surviving spouse is continuing coverage under the Medicare Plus Blue Group PPO Program after your death, the date of the spouse's remarriage or death, whichever occurs first.

Eligibility for Retiree Program Subsidized Self-Payments

An Early Disability and Retiree Benefit self-payment subsidy is established for Participants retiring on or after June 1, 2024, who are eligible for Early and Disability Retiree Benefits. The subsidy percentage will be based on a Retiree's Years of Service earned after beginning participation as an Eligible Employee. The Plan will recognize years of vesting service earned under NEBF as reflected in NEBF benefit statements or other records as "Years of Service" under the Plan. If NEBF service records are unavailable or incomplete, the Trustees will grant a Year of Service for each calendar year in which the Retiree can establish that he or she earned at least 270 hours of vesting service under a pension plan jointly sponsored by a Local Union or from other similar sources that can be verified by evidence that a Retiree produces that the Trustees in their discretion determine is acceptable. In no event will a Retiree be provided with more than one Year of Service for any calendar year.

Self-payments will be based on the following schedule:

Years of Service Category	Discount from Monthly Eligibility Cost
Less than 3	0%/(N/A)
3-9	10%
10-19	20%
20-24	30%
25-29	40%
30+	50%

Participants who first begin participating under the Early Disability and Retiree program prior to June 1, 2024 will receive a self-payment subsidy based on rules adopted by the Trustees in their discretion.

Retiree Returning to Employment with a Contributing Employer

E&D Retirees and Medicare Plus Blue Group PPO Program Retirees Credit for Employer Contributions

If you are making self-payments as a Retiree for either the E&D Retiree Benefits or Medicare Plus Blue Group PPO Program and you return to work as a Bargaining Unit Employee for a Contributing Employer to the Plan, contributions paid on your behalf will be credited as hours toward active Employee Plan coverage.

To requalify for the active Employee Plan coverage, you must earn at least 135 Credit Hours in a single month. For example, if you have 135 Credited Hours in April 2020, you would have coverage

under the Plan as an active Employee effective June 1, 2020. If sufficient Credited Hours are worked and contributions are paid, you will cease to participate under the Retiree program and will instead participate in the Plan as an active Employee.

If your hours decline and you lose eligibility for the Plan as an active Employee, you can return to Retiree coverage under the E&D Retiree Benefits or the Medicare Plus Blue Group PPO Program. If you satisfied the applicable Retiree eligibility criteria when you initially retired, you are deemed to satisfied the eligibility requirements for any subsequent retirements provided you have maintained continuous uninterrupted coverage under the Plan (subject to satisfying the opt-out exceptions under the Plan).

IMPORTANT NOTE: When you are a Retiree under the Medicare Plus Blue Group PPO Program who becomes a Covered Individual as an active Employee, you should immediately notify your Doctors and other medical care providers that your Plan coverage will pay primary before Medicare and Medicare will pay secondary while you have Plan coverage as an active Employee.

Eligibility in the Event of Your Death (Surviving Dependent Coverage)

Active Employees

If you die while you are a Covered Individual and active Employee, your surviving Dependents may be entitled to continue Plan coverage by making self-payments for COBRA coverage or for the Surviving Dependents Program (previously called the Widow Program).

COBRA Coverage

In the event of your death, your surviving spouse (or Dependent Children) may be entitled to make self-payments for COBRA Coverage (see Self-Payment for COBRA Coverage beginning on page 16 for the governing rules).

Surviving Dependents Program

After your death, the Plan Office will apply any eligibility you earned or paid for before your death to your surviving Dependents' eligibility. Then, if your surviving Dependents decline COBRA and want to make self-payments for continued coverage under the Surviving Dependents Program, the rules stated below will apply. The payments may be made by your surviving spouse, or by or on behalf of a surviving Dependent Child (or Children).

Surviving Dependents Program Self-Payment Rules

Your Dependent must make the first payment on or before the date that coverage under the Plan would otherwise terminate. If an on time self-payment is not made, no future self-payments are allowed. The amount of required monthly payment is determined by the Trustees and can be changed at any time.

Your Dependent must contact the Plan Office to apply to make the self-payments. After the first payment, the Plan Office will send a self-payment statement acknowledging that payment. A copy of that form should be used to send in the next payment.

All monthly self-payments after the first payment are due no later than the 15th day of the month for which the payment is being made. If your Dependent fails to make an on-time self-payment, coverage will terminate at the end of the month for which a payment had already been made, and no further self-payments may be made.

Your Dependent can continue to make self-payments for the Surviving Dependents Program until coverage terminates according to the termination rules stated on page 31.

E&D Retirees

If you die while you are eligible for E&D Retiree Benefits, your surviving Dependents may be entitled to continue coverage for E&D Retiree Benefits by making COBRA self-payments according to the COBRA Coverage rules (See page 28).

If your surviving Dependents decline COBRA Coverage, they can make self-payments for continued E&D Retiree Benefits under the Surviving Dependents Program. The payments may be made by your surviving spouse or by or on behalf of a surviving Dependent Child (or Children).

The same self-payment rules that apply to survivors of active Employees will apply, except that:

1. Your Dependent must make the first self-payment on or before the first day of the month following the month during which your death occurs—for example, by May 1 if you die on April 20. If an on-time payment is not made, coverage will terminate and no future self-payments are allowed.

2. Your Dependent spouse can make self-payments until he or she becomes eligible for Medicare or remarries. If your surviving Dependent Child is making the self-payments, payments can be made until the Child ceases to meet the definition of a Dependent (for example, because of age) or becomes eligible for Medicare.

Retirees Covered Under the Medicare Plus Blue Group PPO Program

If you die while both you and your spouse are covered under the Medicare Plus Blue Group PPO Program, or if you are covered under the E&D Retiree Benefits but your spouse is covered under the Medicare Plus Blue Group PPO Program, your spouse will continue to be eligible for the Medicare Plus Blue Group PPO Program until your spouse dies or remarries, whichever occurs first, provided your spouse continues to make the required self-payments.

If you die while only you are covered under the Medicare Plus Blue Group PPO Program and you have been making payments for the E&D Retiree Benefits under the "spouse Plan" for your Dependents, your spouse (and Dependent Children) can continue E&D Retiree Benefits under the Surviving Dependents Program. Your spouse can make the payments until he or she remarries or reaches age 65 and becomes eligible for Medicare, whichever occurs first. If your spouse dies after your death, your Dependent Child's coverage under the Medicare Plus Blue Group PPO Program will cease.

If your spouse does not want to continue coverage for the Surviving Dependents Program E&D Retiree Benefits, your spouse can stop making the payments. Surviving Dependents Program E&D Retiree Benefits will terminate at the end of the period for which payments had already been made. However, even if payments cease, your spouse will still be eligible (unless he or she has remarried) to enroll in the Medicare Plus Blue Group PPO Program upon reaching age 65 and becoming eligible for Medicare, provided he or she is enrolled in both Part A and B of Medicare and makes the required monthly self-payments. Upon becoming eligible for Medicare, your spouse should contact the Plan Office for information about enrolling.

Extension of Comprehensive Medical Benefit

If you are a Covered Individual who is Totally Disabled at the time your coverage would otherwise terminate, limited Comprehensive Medical Benefit will be continued for you for a period of time. The extension of benefits rules apply separately to you and each of your Dependents.

Rules Governing an Extension of Benefits

You must be Totally Disabled at the time your eligibility terminates and remain Totally Disabled to qualify for the extension. Benefits will be payable under an extension only for charges incurred for treatment of the injury or sickness that caused your Total Disability and only to the extent that benefits would normally have been payable had your eligibility not terminated. All maximum benefits, limitations, and exclusions will apply.

If you qualify for an extension of benefits, Comprehensive Medical Benefit will continue for up to 12 months after the date your eligibility terminates. An extension of the Comprehensive Medical Benefit terminates on the first to occur of the following dates:

1. The end of the 12-month period following the date your Plan coverage would otherwise have terminated

2. The date you cease to be Totally Disabled; or

3. The date you become covered under any other welfare fund or group health Plan or any Employer-sponsored health or welfare Plan or Medicare.

Comprehensive Medical Benefit

This section describes the medical benefits available under the Plan. This section does not apply to Medicare eligible persons covered under the Plan's Medicare Advantage Plan.

What You Must Pay

You have PPO coverage under this Plan. PPO coverage uses a “Preferred Provider Organization” provider network. What you must pay depends on the type of provider you choose. If you choose an in-network provider, you most often pay less money than if you choose an out-of-network provider. The types of providers you may get services from are in the chart below.

Choosing Your Provider		
In-Network Provider **Lower Cost**	**Out-of-Network Participating Provider** **Higher Cost**	**Out-of-Network Nonparticipating Provider** **Highest Cost**
BCBSM's Approved Amount* accepted as payment in full. Lower out-of-pocket costs: • Lower Deductible, Copayment and Coinsurance • No Deductible, Copayment or Coinsurance for certain preventive care benefits No claim forms to file	BCBSM's Approved Amount* accepted as payment in full. Higher out-of-pocket costs: • Higher Deductible, Copayment and Coinsurance (unless noted). • No Deductible, Copayment or Coinsurance for certain preventive care benefits No claim forms to file	BCBSM's Approved Amount not accepted as payment in full. In addition to your out-of-network cost share, you may be responsible for the difference between what the Plan pays and what the provider charges (unless noted). You must file claim forms

* The provider accepts BCBSM's Approved Amount minus your cost share as payment in full for the covered services.

A provider can either be participating or nonparticipating. Participating providers cannot bill you for more than the Plan's payment plus what you pay in Cost Sharing. Nonparticipating providers can bill you for the difference between the provider's charge and what the Plan pays plus your out-of-network Cost Sharing.

Some nonparticipating providers can agree to accept the Plan's payment for a service as payment in full. When this occurs, you only have to pay your out-of-network cost-share requirement. Other nonparticipating providers may not accept the Plan's payment as payment in full. In this instance, you will have to pay your out-of-network cost share requirement and the difference between the amount paid to the provider and the provider's charge.

For a list of In-Network Providers, visit bcbsm.com or call BCBSM's Customer Service department at the number on the back of your ID card.

The Deductibles, Copayments and Coinsurances you must pay each Calendar Year are illustrated in the BAAG attached in Appendix A and explained in more detail in the pages that follow.

In-Network Providers

Deductible Requirements

Each Calendar Year, you must pay a Deductible for in-network covered services. The Deductible amount for individual and family coverage is provided in the BAAG. If you have family coverage, two or more members must meet the family Deductible. If the one-member Deductible has been met, but not the family Deductible, the Plan will pay for covered services only for that member who has met the Deductible. Covered services for the remaining family members will be paid when the full family Deductible has been met.

Payments applied to your in-network Deductible in the last three months of a Calendar Year will be applied toward your in-network Deductible requirement for the next Calendar Year.

You are not required to pay a Deductible for the following:

1. Covered services performed in an in-network Physician's office, including mental health and substance use disorder services that are equal to an office visit
2. Services subject to a Copayment requirement
3. Professional services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a Hospital, urgent care center or Physician's office
4. Osteopathic manipulation

5. Chiropractic manipulation

6. Prenatal and postnatal care visits

7. Allergy testing and therapy

8. Therapeutic injections

9. Hospice care benefits

10. Preventive care services (specific services are listed on page 79)

Copayment and Coinsurance Requirements

You must pay the Copayment amounts for covered services by In-Network Providers listed in the BAAG.

The Copayment per visit for facility services in a Hospital emergency room is not applied if the patient is admitted or services were required to treat an accidental injury

Note: You do not have to pay a Copayment for in- or out-of-network Physician services, for treatment for a medical emergency or accidental injury. However, if you receive services from a non-participating provider, you may have to pay the difference between what the Plan pays and the provider's charge.

The Copayment per office visit, office consultation, online visit, urgent care visit, or visit in a retail health clinic does not apply to:

1. First aid and medical emergency treatment

2. Prenatal and postnatal care visits

3. Allergy testing and therapy

4. Therapeutic injections

5. Presurgical consultations

You must pay the Copayment amount listed in the BAAG per chiropractic or osteopathic manipulative treatment, when services are given in a Physician's office.

Note: When an office visit and a manipulative treatment service are billed on the same day, by the same in-network Physician, only one Copayment will be required for the office visit.

In addition to your Deductible, you must pay the Coinsurance for covered services by In-Network Providers provided in the in the BAAG.

This Coinsurance does <u>not</u> apply to:

1. Services in an in-network Physician's office, except mental health and substance use disorder services that are not equal to an office visit. These services will require payment of your Coinsurance.

2. Services in a retail health clinic

3. Services subject to a Copayment requirement

4. Professional services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a Hospital, urgent care center or Physician's office

5. Chiropractic and osteopathic manipulation

6. Prenatal and postnatal care visits

7. Allergy testing and therapy

8. Therapeutic injections

9. Hospice care benefits

10. Preventive care services (specific services are listed on page 79)

11. Presurgical consultations

Annual Coinsurance Maximum

Each Calendar Year, the Coinsurance you pay for most covered services is limited to the maximum set forth in the BAAG. If you have family coverage, two or more members must meet the family Coinsurance maximum. If a member meets the one-member Coinsurance maximum, but the family Coinsurance maximum has not been met, the Plan will not require any more Coinsurance for that member for the remainder of the Calendar Year. Coinsurance for the remaining family members will be required until the full family annual Coinsurance maximum has been met.

Exceptions

Cost-sharing paid for the following services is not applied toward the annual Coinsurance maximum:

1. Deductibles

2. Services that require flat dollar Copayments

3. Private duty nursing

4. Prescription drug services

Coinsurance applied toward the annual Coinsurance maximum for out-of-network services also counts toward the Coinsurance maximum for in-network services. However, Coinsurance paid for in-network services is not applied toward the annual Coinsurance maximum for out-of-network services.

Coinsurance applied toward the annual Coinsurance maximum for in-network services also applies to your annual out-of-pocket maximum.

Once the annual Coinsurance maximum is met, no more Coinsurance will be required for the remainder of the year, except that Coinsurance will continue to be required for private duty nursing and prescription drug services, if covered, until your annual out-of-pocket maximum is reached.

Annual Out-of-Pocket Maximums

Your annual out-of-pocket maximum for covered in-network services is provided in the BAAG. If you have family coverage, two or more members must meet the family out-of-pocket maximum. If the one member maximum is met even if the family maximum is not, that member does not pay any more Cost Sharing for the rest of the Calendar Year. Cost Sharing for the remaining family members must still be paid until the annual family maximum is met.

The in-network Deductible, Copayments and Coinsurance that you pay are combined to meet the annual in-network maximum. This includes those for prescription drugs if you have prescription drug coverage through BCBSM. However, the following prescription drug expenses will not apply toward the annual out-of-pocket maximum:

1. Payment for noncovered drugs or services

2. Any difference between the Maximum Allowable Cost and BCBSM's Approved Amount for a covered brand name drug

3. The 25 percent member liability for covered drugs obtained from a nonparticipating pharmacy

4. Amounts paid by a Prescription Drug Assistance Program

Note: Only payments toward your cost-share are applied toward your out-of-pocket maximum. If you receive services from a nonparticipating provider and you are required to pay that provider for the difference between the charge for the services and the Approved Amount, your payment will not apply to your out-of-pocket maximum.

Once you meet the maximums for the year, the Plan pays for all covered benefits at 100 percent of the Approved Amount for the rest of the Calendar Year.

Out-of-Network Providers

Deductible Requirements

Each Calendar Year, you must pay the Deductible for out-of-network covered services that is provided in the BAAG. If you have family coverage, two or more members must meet the family Deductible. If the one-member Deductible has been met, but not the family Deductible, the Plan will pay covered services only for that member who has met the Deductible. Covered services for the remaining family members will be paid when the full family Deductible has been met.

Note: Payments applied to your out-of-network Deductible also count toward your in-network Deductible. However, payments applied to your in-network Deductible do not count toward your out-of-network Deductible.

You do not have to pay an out-of-network Deductible for:

1. Services provided by an out-of-network provider, when an in-network provider has referred you.

Note: You must get the referral prior to receiving the referred services; otherwise, the services will be subject to your out-of-network Deductible.

2. Professional services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a Hospital, urgent care center or Physician's office.

3. Services from a provider for which there is no PPO network.

4. Services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

In limited instances, you may not have to pay an out-of-network Deductible for select professional services performed by Out-of-Network Providers in an in-network Hospital, participating freestanding Ambulatory Surgery Facility or any other location identified by BCBSM

Copayment and Coinsurance Requirements

You must pay the Copayment amounts for covered services by Out-of-Network Providers listed in the BAAG.

The Copayment per visit for facility services in a Hospital emergency room is not applied if:

1. The patient is admitted; or

2. Services were required to treat an accidental injury.

In addition to your Deductible, you must pay the Coinsurance for covered services by Out-of-Network Providers provided in the BAAG.

Note: Online visits by an out-of-network professional provider will be subject to applicable out-of-network cost-sharing requirements. Online visits by an online vendor will not be covered.

You do not have to pay the out-of-network Coinsurance for:

1. Services provided by an out-of-network provider, when an in-network provider has referred you.

Note: You must get the referral prior to receiving the referred services; otherwise, the services will be subject to your out-of-network Coinsurance.

2. Professional services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a Hospital, urgent care center or Physician's office.

3. A prescription for a contraceptive device obtained from an out-of-network provider.

4. Services from a provider for which there is no PPO network.

5. Services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

In limited instances, you may not have to pay out-of-network Coinsurance for select professional services performed by Out-of-Network Providers in an in-network Hospital, participating freestanding Ambulatory Surgery Facility or any other location identified by BCBSM.

Note: You may contact BCBSM for more information about these services.

Annual Coinsurance Maximum

Each Calendar Year, the Coinsurance you pay for most covered services is limited to the maximum set forth in the BAAG. If you have family coverage, two or more members must meet the family Coinsurance maximum. If a member meets the one-member Coinsurance maximum, but the family Coinsurance maximum has not been met, the Plan will not require any more Coinsurance for that member for the remainder of the Calendar Year. Coinsurance for the remaining family members will be required until the full family annual Coinsurance maximum has been met.

Exceptions

Cost-sharing paid for the following services is not applied toward the annual Coinsurance maximum:

1. Deductibles

2. Services that require flat dollar Copayments

3. Private duty nursing

4. Prescription drug services

Coinsurance applied toward the annual Coinsurance maximum for out-of-network services also counts toward the Coinsurance maximum for in-network services. However, Coinsurance paid for in-network services is not applies toward the annual Coinsurance maximum for out-of-network services.

Coinsurance applied toward the annual Coinsurance maximum for out-of-network services also applies to your annual out-of-pocket maximum.

Once the annual Coinsurance maximum is met, no more Coinsurance will be required for the remainder of the year, except that Coinsurance will continue to be required for private duty nursing and prescription drug services, if covered, until your annual out-of-pocket maximum is reached.

Annual Out-of-Pocket Maximums

Your annual out-of-pocket maximum for covered out-of-network services is provided in the BAAG. If you have family coverage, two or more members must meet the family out-of-pocket maximum. If the one-member maximum is met even if the family maximum is not, that member does not pay any more cost-sharing for the rest of the Calendar Year. Cost-sharing for the remaining family members must still be paid until the annual family maximum is met.

The out-of-network Deductible, Copayments and Coinsurance that you pay are combined to meet the annual out-of-network maximum. This includes those for prescription drugs if you have prescription drug coverage through BCBSM. If you do however, the following prescription drug expenses will not apply toward the annual out-of-pocket maximum:

1. Payment for noncovered drugs or services

2. Any difference between the Maximum Allowable Cost and BCBSM's Approved Amount for a covered brand name drug

3. The 25 percent member liability for covered drugs obtained from a nonparticipating pharmacy

4. Amount paid by a Prescription Drug Assistance Program

Note: Only payments toward your cost-share are applied toward your out-of-pocket maximum. If you receive services from a nonparticipating provider and you are required to pay that provider for the difference between the charge for the services and the Approved Amount, your payment will not apply to your out-of-pocket maximum.

Once you meet the maximums for the year, the Plan pays for all covered benefits at 100 percent of the Approved Amount for the rest of the Calendar Year.

Note: What you pay in out-of-network cost-sharing also counts toward your in-network out-of-pocket maximum. However, what you pay in in-network cost-sharing does not count toward your out-of-network maximum.

Value Based Program

When received in-network, you do not pay a Deductible, Copayment, or Coinsurance for care management services. These services include:

1. Provider-Delivered Care Management (PDCM)

2. Services obtained only in Michigan from providers designated by BCBSM.

3. Blue Distinction Total Care (BDTC)

4. Services obtained outside of Michigan from providers designated by the local Blue Cross Blue Shield Plan in that state.

When received out-of-network, you are responsible for the provider's full charge.

Prior Authorization for Select Services

Some health care services and admissions must be reviewed and approved before they are covered. This is called prior authorization, preauthorization or preapproval. If prior authorization is needed, your Doctor or health care provider should request it on your behalf. The review process begins once the request is received. Accordingly, it is important that all relevant materials needed for the review are submitted with the request.

If you do not obtain prior authorization when it is required:

1. Your claim will not be covered.

2. A participating provider or facility that provided the care cannot bill you for the cost of the admission or services.

3. A nonparticipating provider or facility that provided the care may require you to pay for the admission and services.

When services are reviewed, that does not guarantee your claim will be covered. In certain circumstances, review is needed to ensure the service is Medically Necessary and appropriate for your situation.

If you disagree with a decision regarding prior authorization, you can appeal.

The following are some of the services that need prior authorization. Other services and admissions for which prior authorization is required are described in the applicable subsections of this SPD. For a complete list of admissions and services requiring prior authorization call BCBSM Customer Service.

Note: Prior authorization is not required for Emergency Services.

Services Requiring Prior Authorization

- Certain Radiology Services, including:
    - Computed tomography (CT)
    - Computed tomography angiography (CTA)
    - Echocardiology
    - Magnetic resonance imaging (MRI)
    - Magnetic resonance angiography (MRA)
    - Magnetic resonance spectroscopy (MRS)
- Nuclear cardiology
- Positron emission tomography (PET)
- Quantitative computed tomography (QCT) bone densitometry
- Inpatient care:
- Acute
- Lumbar spinal fusion
- Mental health care, including residential psychiatric admissions
- Substance use disorder treatment
- In-lab sleep studies
- Interventional pain management
- Skilled nursing facility care
- Human organ transplant services
- Radiation therapy (oncology)
- Rehabilitation therapy
- repetitive Transcranial Magnetic Stimulation (rTMS)
- Gender reassignment surgery
- Freestanding substance use disorder facilities
- Applied behavioral analysis

Prior authorization is also required for specialty pharmaceuticals. (For additional information, see Prior Authorization for Specialty Pharmaceuticals in the Prescription Drugs section on page 78.) Select prescription drugs also require prior authorization. (For additional information, see Mandatory Prior Authorization in the Prescription Drugs section on page 103).

Some prescription drug services require prior authorization before you receive them. If you receive those services without first obtaining prior authorization, you may have to pay the bill yourself. The Plan may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive these services.

Covered Services

This section describes the services the Plan pays for and the extent to which they are covered.

The Plan pays only for "Medically Necessary" services (see Definitions section of this booklet for the definition). This includes services that may not be covered under this Plan but are part of an approved treatment Plan. There are exceptions to this rule. Here are some examples:

1. Voluntary sterilization
2. Screening mammography
3. Preventive care services
4. Contraceptive services

Note: The Plan will not pay for Medically Necessary services in an inpatient setting if they can be safely given in an outpatient location or office setting.

Some admissions and services must be approved before they occur (see the Prior Authorization for Select Services subsection above for additional details). Emergency Services do not need to be preapproved.

The Plan pays the BCBSM Approved Amount (see Definitions section for the definition of Approved Amount) for the services you receive that are covered in the Plan documents. You must pay your cost share for many of the benefits listed.

The Plan pays for covered services you receive in Hospitals and other BCBSM-approved facilities. Your Physician must prescribe the services before the Plan will cover them. Covered services must be provided by BCBSM-approved providers who are legally qualified or licensed to provide them.

Note: Some Physicians and other providers do not participate with BCBSM. They do not bill BCBSM, but bill you instead. If you receive services from such a provider, the provider may bill you more than what the Plan pays. The Plan will reimburse you the Approved Amount but you must pay your cost share and the difference between what the Plan pays and the provider's charge. See Nonparticipating Physicians and Other Providers section for additional information.

Allergy Testing and Therapy

Locations: The Plan pays for allergy testing and therapy in:

1. A participating Hospital
2. A participating Ambulatory Surgery Facility
3. An office.

The Plan pays for:

1. Allergy Testing
2. Survey, including history, physical exam, and diagnostic laboratory studies
3. Intradermal, scratch and puncture tests
4. Patch and photo tests
5. Double-blind food challenge test and bronchial challenge test
6. Allergy Therapy
7. Allergy immunotherapy by injection (allergy shots)
8. Injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

The Plan does not pay for:

1. Fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria)
2. Self-administered, over-the-counter drugs
3. Psychological testing, evaluation, or therapy for allergies
4. Environmental studies, evaluation, or control

Ambulance Services

The Plan pays for:

1. Ground and air ambulance services to take a patient to a covered destination.

2. For ground ambulance, a covered destination may include:

    - A Hospital
    - A skilled nursing facility
    - A member's home
    - A dialysis center
    - For air ambulance, a covered destination may include:
    - A Hospital
    - Another covered facility, with preapproval

3. The Plan will pay for a member to be taken to the nearest approved destination capable of providing the level of care necessary to treat the patient's condition.

Note: Transfer of the patient between covered destinations must be prescribed by the attending Physician.

4. Ground and air ambulance services when the ambulance arrives at the scene but transport is not needed or is refused.

5. The ambulance arrives at the scene but the patient has expired.

6. Air ambulance services are covered only if:

    - No other means of transportation are available
    - The patient's condition requires transportation by air ambulance rather than ground ambulance
    - The provider is not a commercial airline
    - The patient is taken to the nearest facility capable of treating the patient's condition

In every case the service must be Medically Necessary. Any other means of transport would endanger the patient's health.

The Plan only pays for the transportation of the patient and whatever care is required during transport. The Plan does not pay for other services that might be billed with it.

The service must be provided in a vehicle licensed as a ground or air ambulance and which is part of a licensed ambulance operation.

Note: Your coverage includes BCBSM's Case Management program. Air ambulance transportation that does not meet the requirements described above is eligible for review and possible approval under the Case Management provision of your coverage. Case Management may recommend coverage for transportation that positively impacts clinical outcomes, but not for a patient's or family's convenience.

The Plan does not pay for:

1. Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.

2. Air ambulance services when the member's condition does not require air ambulance transport.

Anesthesiology Services

Locations: The Plan pays for anesthesiology services in a:

1. A participating Hospital
2. A participating Ambulatory Surgery Facility
3. An office

The Plan pays for:

1. Anesthesiology during surgery**.** Anesthesia services given to patients undergoing covered surgery are payable to:
    - A Physician other than the operating Physician

Note: If the operating Physician gives the anesthetics, the service is included in the payment for the surgery.

- A Physician who orders and supervises anesthesiology services
- A certified registered nurse anesthetist (CRNA). CRNA services must be:
    - Directly supervised by the Physician performing the surgery or procedure or
    - Under the indirect supervision of the Physician responsible for anesthesiology services

Note: If a CRNA is an Employee of a Hospital or facility, the Plan pays the facility directly for the anesthesia services.

2. Anesthesia during infusion therapy

Note: The Plan pays for local anesthesia only when needed as part of infusion therapy done in an office.

3. Other Services

Note: Anesthesia services may also be covered as part of electroconvulsive therapy (see page 66) and for covered dental services (see page 114).

Audiologist Services

Locations: The Plan pays for audiology services performed by an audiologist in an office and other outpatient locations.

The Plan pays for: Services performed by an audiologist, if they are prescribed by a provider who is legally authorized to prescribe the services.

Autism Disorders

Locations: The Plan pays for treatment of approved autism spectrum disorders in the following locations:

1. An office
2. A member's home
3. Other approved outpatient locations

The Plan pays for:

1. The diagnosis and outpatient treatment of autism spectrum disorders, including:
    - Autistic Disorder

- Asperger's Disorder
- Pervasive Developmental Disorder Not Otherwise Specified

as each are defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

2. Diagnostic services provided by a properly licensed provider, including: assessments and evaluations or tests, including the Autism Diagnostic Observation Schedule.

   Note: The Autism Diagnostic Observation Schedule is the protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the director of the Michigan Department of Insurance and Financial Services, if the director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

3. Treatment prescribed by a properly licensed provider, including:

   - Applied Behavior Analysis (ABA) treatment. ABA treatment is subject to the following requirements:
     - Treatment plan – A BCBSM-approved autism evaluation center that evaluates the member will recommend a treatment plan. The plan must include ABA treatment. If BCBSM requests treatment review, BCBSM will pay for it.

       Note: An autism evaluation center is an academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders.

     - Preapproval – ABA treatment must be approved by BCBSM before treatment is given. If not, you will have to pay for it. Other autism services do not have to be approved beforehand.

     - Treatment must be provided or supervised by a Behavior Analyst Certification Board certified behavior analyst or a licensed psychologist.

   - Behavioral Health Treatment – Evidence-based counseling and treatment programs, including ABA, that meet both of the following requirements:
     - Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

     - Are provided or supervised by a board-certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

   - Psychiatric care, including a psychiatrist's direct or consulting services.
   - Psychological care, including a psychologist's direct or consulting services.
   - Therapeutic care. Evidence-based services from licensed providers, including:
     - Physical therapy
     - Occupational therapy
     - Speech and language pathology
     - Services from a social worker
     - Nutritional therapy from a physician
     - Genetic testing, as recommended in the treatment plan

       Note: Benefits for autism treatment are in addition to any other mental health or medical benefits provided by the Plan.

<u>The Plan does not pay for:</u>

- ABA treatment for members over the age of 18. This limitation does not apply to:
  - Other mental health services to treat or diagnose autism

- Medical services, such as physical therapy, occupational therapy, speech and language pathology services, genetic testing or nutritional therapy to treat or diagnose autism

- Treatment of conditions such as Rett's Disorder or Childhood Disintegrative Disorder.
- Treatments that are otherwise excluded under the Plan, such as sensory integration therapy or chelation therapy.

Limitations and Exceptions

- When a member receives physical therapy, occupational therapy or speech and language pathology for treatment of a covered autism disorder, those services do not apply to the benefit maximums listed in this certificate.
- When a member receives preapproved services for covered autism disorders, coverage for the services under this autism benefit overrides certain exclusions in the Plan such as the exclusion of:
  - Experimental treatment
  - Treatment of chronic, developmental or congenital conditions
  - Treatment of learning disabilities or inherited speech abnormalities
  - Treatment solely to improve cognition, concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

Cardiac Rehabilitation

Locations: The Plan pays for cardiac rehabilitation participating Hospital.

The Plan pays for:

1. Services that began during a Hospital admission for an invasive cardiovascular procedure (*e.g.*, heart surgery) or an acute cardiovascular event (*e.g.*, heart attack)

2. Services given when intensive monitoring (*i.e.*, through the use of EKGs) and/or supervision during exercise is required.

The Plan does not pay for: Services that require less than intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable

Chemotherapy

The Plan pays for chemotherapeutic drugs. Because specialty pharmaceuticals may be used in chemotherapy treatment, please see the prior authorization requirement for Chemotherapy Specialty Pharmaceuticals described on page 105.

To be payable, the drugs must be:

1. Ordered by a Physician for the treatment of a specific type of malignant disease

2. Provided as part of a chemotherapy program and

3. Approved by the Federal Food and Drug Administration (FDA) for use in chemotherapy treatment

Note: If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy department determines the appropriateness of the drug for that disease by using the following criteria:

- Current medical literature must confirm that the drug is effective for the disease being treated
- Recognized oncology organizations must generally accept the drug as treatment for the specific disease
- The Physician must obtain informed consent from the patient for the treatment.

The Plan also pays for:

1. Physician services for the administration of the chemotherapy drug, except those taken orally
2. The chemotherapy drug administered in a medically approved manner
3. Other FDA-approved drugs classified as:
   - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
   - Drugs used to enhance chemotherapeutic drugs
   - Drugs to prevent or treat the side effects of chemotherapy treatment
4. Infusion pumps used for the administration of chemotherapy, administration sets, refills and maintenance of implantable or portable pumps and ports

Note: Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines described on page 58.

5. Outpatient treatment of breast cancer

For high dose chemotherapy used in bone marrow transplants, see page 92.

Chiropractic Services and Osteopathic Manipulative Therapy

Locations: The Plan pays for chiropractic services and osteopathic manipulative therapy in an office.

The Plan pays for:

1. Osteopathic manipulation therapy (OMT) on any location of the body.
2. Chiropractic spinal manipulation (CSM) to treat misaligned or displaced vertebrae of the spine and chiropractic manipulations (CM) to treat other areas of the body allowed by BCBSM

Note: The Plan pays up to a combined maximum of 24-visits per member per Calendar Year for OMT, CM and CSM. Visits with in-network and Out-of-Network Providers count toward this maximum.

3. Chiropractic office visits:
   - For new patients: the Plan pays for one office visit every 36 months. A new patient is one who has not received chiropractic services within the past 36 months.
   - For established patients: the Plan pays for medical office visits. An established patient is one who has received chiropractic services within the past 36 months.
4. Physical therapy that is part of a physical therapy treatment Plan prepared by your chiropractor. The Plan must be signed by your M.D. or D.O. before you receive physical therapy services for those services to be covered. If a treatment Plan is not signed by your M.D. or D.O. before services are rendered, the services will not be covered and you may have to pay for them.

   A signed treatment Plan is not required for the first physical therapy service your chiropractor performs on you.

Note: Visits for physical therapy are applied toward your combined 60-visit benefit limit for physical therapy, speech and language pathology, and occupational therapy services. Any combination of these

therapies is limited to a combined maximum of 60-visits (in-network and Out-of-Network Providers combined) per member per Calendar Year:

- Mechanical traction
- Occupational therapy
- Physical therapy, and
- Speech and language pathology

5. Mechanical traction once per day when it is given with CM or CSM. These visits are applied toward your combined 60-visit limit for occupational therapy, physical therapy, and speech and language pathology therapy services.

6. X-rays when Medically Necessary.

Chronic Disease Management

Locations: The Plan pays for services to manage chronic diseases in:

1. A participating Hospital
2. An office
3. A participating facility
4. A member's home

The Plan pays for: Chronic disease management services provided by:

1. Participating Hospitals
2. Physicians
3. Participating facilities
4. Certified nurse practitioners
5. Certified licensed social workers
6. Psychologists
7. Physical therapists

Clinical Trials (Routine Patient Costs)

The Plan pays the routine costs of items and services related to Clinical Trials. The trials may be Phase I, II, III or IV. The purpose of the trial must be to prevent, detect or treat cancer or another life-threatening disease or condition. The member receiving the items or services must be a Qualified Individual according to the terms of the Plan.

The Plan pays for: All routine services covered under the Plan that would be covered even if the member were not enrolled in an Approved Clinical Trial

The Plan does not pay for:

1. The experimental or investigational item, device or service itself
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Note: BCBSM may require you to go to a BCBSM-contracted provider who is already part of an Approved Clinical Trial. The provider may be participating or in-network. An exception would be if the trial is conducted outside of Michigan.

Dental Services

Locations: The Plan pays for emergency dental care given in:

1. A Hospital
2. An Ambulatory Surgery Facility
3. A dentist's office (accidental injuries only)

The Plan pays for other dental services in a participating Hospital or a provider's office as described below.

The Plan pays for:

1. Emergency dental care for the treatment of accidental injuries within 24 hours of the injury to relieve pain and discomfort. Follow-up treatment completed within 6 months of the injury is also covered.

Note: A dental accidental injury is when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, gums or bone.

2. The Plan will pay for dental treatment for a patient in a participating Hospital if the treatment helps improve the medical condition that put the patient in the Hospital. The dental condition must be hindering improvement of the medical condition. Examples of such medical conditions are:

    - Bleeding or clotting abnormalities
    - Unstable angina
    - Severe respiratory disease
    - Known reaction to analgesics, anesthetics, etc.
    - Medical records must confirm the need for the dental services above.
    - Procedures that are payable in the circumstances explained above include:
    - Alveoloplasty
    - Diagnostic X-rays
    - Multiple extractions or removal of unerupted teeth

    The Plan may pay for facility and anesthesia services for a patient in a participating Hospital if dental treatment would be unsafe in an office setting

Note: In these cases, the Plan does not pay for the services of the dentist. The Plan will only pay for the facility and anesthesia services.

3. Other Dental Services
4. Services to treat temporomandibular joint dysfunction (TMJ) limited to those described below:

    - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
    - Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction)
    - Diagnostic X-rays
    - Physical therapy (see page 75 for physical therapy services)

- Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

The Plan does not pay for:

1. Routine dental services (coverage may be available under other sections of the Plan)
2. Treatment that was previously paid as a result of an accident
3. Dental implants and related services, including repair and maintenance of implants and surrounding tissue
4. Dental conditions existing before an accident requiring emergency dental treatment
5. Services to treat temporomandibular joint dysfunction (except as described above.)

Diagnostic Services

Locations: the Plan pays for diagnostic services in:

1. A participating Hospital
2. A participating Ambulatory Surgery Facility
3. A participating skilled nursing facility
4. An office

The Plan pays for:

1. Diagnostic Testing. The Plan pays for the tests a Physician uses to diagnose disease, illness, pregnancy or injury.
    - Physician services are payable for tests such as:
        - Thyroid function
        - Electrocardiogram (EKG)
        - Electroencephalogram (EEG)
        - Pulmonary function studies
    - Physician and independent physical therapist services are payable for the following tests:
        - Electromyogram (EMG)
        - Nerve conduction

Note: The test must be prescribed by a Physician if performed by an independent physical therapist.

2. Diagnostic Laboratory and Pathology Services. The Plan pays for the lab and pathology tests a Physician uses to diagnose disease, illness, pregnancy or injury. Services must be provided:
    - In a participating Hospital (under the direction of a pathologist employed by the Hospital) or
    - By your in-network Physician, or
    - By another Physician, if your in-network Physician refers you to one, or
    - By an in-network lab at your in-network Physician's direction.

The Plan pays for standard office lab tests in your in-network Physician's office. Other lab tests must be sent to an in-network laboratory. You will need to pay the out-of-network cost-share if tests are done by an out-of-network lab or in an out-of-network Hospital.

However, some services are not subject to the diagnoses restrictions, the co-insurance requirement or the Deductible requirements. The following laboratory services are covered at 100 percent of the BCBSM Approved Amount regardless of the diagnoses: Thyroid hormone (T3 or T4), Thyroid stimulating hormone (TSH), assay of PSA, total.

Dialysis Services

BCBSM shares the cost of treating End Stage Renal Disease (ESRD) with Medicare. It is important that you apply for Medicare coverage if you have ESRD. This is done through the Social Security Administration.

Locations: The Plan pays for dialysis services in:

1. A participating Hospital
2. A participating freestanding ESRD facility
3. A member's home

The Plan pays for: Dialysis services (including Physician services), supplies and equipment to treat:

1. Acute renal (kidney) failure
2. Chronic, irreversible kidney failure

End Stage Renal Disease

The Plan pays for treatment of ESRD until the patient becomes eligible for Medicare. This period is a maximum of three months from when you apply for Medicare. Afterward BCBSM shares the cost of treatment with Medicare. See page 33 for details about ESRD.

Services Provided in a Freestanding ESRD Facility

The Plan pays for:

1. Use of the freestanding end stage renal disease facility
2. Ultrafiltration
3. Equipment
4. Solutions
5. Routine laboratory tests
6. Drugs
7. Supplies
8. Other Medically Necessary services related to dialysis treatment

The Plan does not pay for:

1. Services provided by a nonparticipating end stage renal disease facility.
2. Services not provided by the Employees of the ESRD facility.
3. Services not related to the dialysis process.

Services Provided in the Home: Dialysis services (hemodialysis and peritoneal dialysis) must be billed by a Hospital or freestanding ESRD facility participating with BCBSM and must meet the following conditions:

1. The treatment must be arranged by the member's attending Physician and the Physician director, or a committee of staff Physicians of a self-dialysis training program.

2. The owner of the member's home must give the Hospital prior written permission to install the equipment.

The Plan pays for:

1. Home hemodialysis

   - Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
   - Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guidelines

2. Placement and maintenance of a dialysis machine in the member's home

3. Expenses to train the member and one other person who will assist the member in the home in operating the equipment

4. Laboratory tests related to the dialysis

5. Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs

6. Removal of the equipment after it is no longer needed

The Plan does not pay for:

1. Services provided by persons under contract with the Hospital, agencies or organizations assisting in the dialysis or acting as "backups" including Hospital personnel sent to the member's home

2. Electricity or water used to operate the dialyzer

3. Installation of electric power, a water supply or a sanitary waste disposal system

4. Transfer of the dialyzer to another location in the member's home

5. Physician services not paid by the Hospital

Durable Medical Equipment

Locations: The Plan pays for durable medical equipment in:

1. A participating Hospital

2. A participating skilled nursing facility (see Page 81)

3. An office

4. A member's home

The Plan pays for:

1. The use of durable medical equipment while you are in the Hospital.

2. The rental or purchase of durable medical equipment, if prescribed by a Physician or other provider licensed to prescribe it. You may obtain it from:

   - A participating Hospital (when you are discharged)
   - A DME supplier

Note: In many instances, the Plan covers the same items covered by Medicare Part B as of the date of purchase or rental. In some instances, however, BCBSM guidelines may differ from Medicare. Please call your local Customer Service center for specific coverage information.

DME items must meet the following guidelines:

- The prescription includes a description of the equipment, the reason for the need, and the diagnosis.
- The Physician or other provider licensed to prescribe it writes a new prescription when the current prescription expires; otherwise, the Plan will stop payment on the current expiration date, or 30 days after the date of the patient's death, whichever is earlier.

Note: If the equipment is:

- Rented, the Plan will not pay for the charges that exceed the BCBSM purchase price. Participating providers cannot bill the member when the total of the rental payments exceeds the BCBSM purchase price.
- Bought, the Plan will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

3. Continuous Positive Airway Pressure (CPAP). When prescribed by a Physician or other provider licensed to prescribe it, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

   - The Plan covers the rental fee only for the CPAP device. The total rental payments will not exceed the Approved Amount to purchase the device. Once rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by the Plan for the device.
   - The Plan will pay for the rental or purchase of a humidifier for the CPAP device, if needed.
   - The Plan pay for the purchase of any related supplies and accessories.
   - After the first 90 days of rental, you are required to show that you have complied with treatment requirements for the Plan to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier or your prescriber must document your compliance.
   - If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment. The Plan will also no longer cover the purchase of supplies and accessories.

The Plan does not pay for:

1. Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats
2. Deluxe equipment, such as motorized wheelchairs and beds, unless Medically Necessary and required so that patients can operate the equipment themselves
3. Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners
4. Provider's equipment, such as stethoscopes
5. Self-help devices not primarily medical in nature, such as sauna baths and elevators
6. Experimental equipment

Emergency Treatment

Locations. The Plan pays for services to treat medical emergencies and accidental injuries (see page 2 for the definitions) in:

1. A Hospital
2. An urgent care center
3. An office
4. Other approved outpatient locations

The Plan pays for**:** Facility and professional services to examine and treat a medical emergency or accidental injury.

Gender Dysphoria Treatment

The Plan pays for: Medically Necessary services for the treatment of gender dysphoria. This includes professional and facility services.

We do not pay for: Gender reassignment services that are considered by BCBSM to be:

1. Cosmetic, or
2. Treatment that is experimental or investigational

Home Health Care Services

Locations: The Plan pays for care and services provided in a member's home. Home health care must be:

1. Prescribed by the attending Physician
2. Provided and billed by a participating home health care agency
3. Medically Necessary (See page 7 for a definition)
4. The following criteria for home health care must be met:
    - The attending Physician certifies that the patient is confined to the home because of illness. This means that transporting the patient to a health care facility, an office or Hospital for care and services would be difficult due to the nature or degree of the illness.
    - The attending Physician prescribes home health care services and submits a detailed treatment Plan to the home health care agency.
    - The agency accepts the patient into its program.

The Plan pays for:

1. Services provided by health care professionals employed by the home health care agency or by providers who participate with the agency in this program. The agency must bill Plan for the services. They are:
    - Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
    - Social services by a licensed social worker, if requested by the patient's attending Physician
    - The following when provided for rehabilitation:

- Occupational therapy, page 68
- Physical therapy, page 75
- Speech and language pathology services, page 85

If services in a member's home are billed by a home health care agency, then these services will not count toward the visit maximums. If physical therapy, occupational therapy or speech and language pathology services cannot be done in the home, the Plan will pay for outpatient therapy. It may be in an outpatient department of a Hospital or a physical therapy facility. Benefits are subject to the combined 60-visit maximum described on pages 69,75, and 85.

If services in a member's home are billed by a professional provider or independent therapist, they will count toward the visit maximum.

- Part-time health aide services, including preparing meals, laundering, bathing and feeding **if**:
  - The patient is receiving skilled nursing care or physical therapy or speech and language pathology services
  - The patient's family cannot provide the services **and** the home health care agency has identified a need for these services for the patient to participate in the program
  - The services are provided by a home health aide and supervised by a registered nurse employed by the agency

2. Home health services provided by a participating Hospital:

- Lab services, prescription drugs, biologicals and solutions related to the condition for which the patient is participating in the program
- Medical and surgical supplies such as catheters, colostomy supplies, hypodermic needles and oxygen needed to effectively administer the medical treatment Plan ordered by the Physician

The Plan does not pay for:

1. General housekeeping services
2. Transportation to and from a Hospital or other facility
3. Private duty nursing
4. Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)
5. Durable medical equipment
6. Physician services (when billed by the home health care agency)
7. Custodial or nonskilled care
8. Services performed by a nonparticipating home health care provider

Hospice Care Services

Locations: The Plan pays for Hospice care services in:

1. A participating Hospice facility
2. A participating Hospital
3. A participating skilled nursing facility
4. A member's home

The Plan pays for services to care for the terminally ill. Services must be provided through a participating Hospice program. Hospice care services are payable for four 90-day periods.

To be payable, you or your personal representative must elect Hospice care services in writing. This written statement must be filed with a participating Hospice program. In addition, the following certifications are submitted to the Plan:

1. For the first 90 days of Hospice care coverage: A written certification stating that the member is terminally ill, signed by the:

   - Medical director of the Hospice program or
   - Physician of the Hospice interdisciplinary group and
   - Attending Physician, if the member has one

2. For the second 90-day period (submitted no later than two days after this 90-day period begins): The Hospice must submit a **second** written certification of terminal illness signed by the:

   - Medical director of the Hospice or
   - Physician of the Hospice interdisciplinary group

3. For the third 90-day period (submitted no later than two days after this 90-day period begins): The Hospice must submit a **third** written certification of terminal illness signed by the:

   - Medical director of the Hospice or
   - Physician of the Hospice interdisciplinary group

4. For the fourth 90-day period (submitted no later than two days after this 90-day period begins): The Hospice must submit a **fourth** written certification of terminal illness signed by the:

   - Medical director of the Hospice or
   - Physician of the Hospice interdisciplinary group
   - The member or his or her representative must sign a "Waiver of Benefits" form acknowledging that Hospice care has been fully explained to them. The waiver explains that BCBSM does not pay for treatment of the terminal illness itself or related conditions during Hospice care.

Note: BCBSM benefits for conditions not related to the terminal illness remain in effect.

The Plan pays for:

1. Counseling, evaluation, education and support services for the member and his or her family from the Hospice staff before the member elects to use Hospice services. These services are limited to a 28-visit maximum.

2. When a member elects to use Hospice care services, regular coverage for services in connection with the terminal illness and related conditions are replaced by the following:

   - Home Care Services
     - Up to eight hours of routine home care per day
     - Continuous home care for up to 24 hours per day during periods of crisis
     - Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse.
   - Facility Services
     - Inpatient care provided by:
       - A participating Hospice inpatient unit
       - A participating Hospital contracting with the Hospice program or

- A participating skilled nursing facility contracting with the Hospice program

- Short-term general inpatient care when the member is admitted for pain control or to manage symptoms. (These services are payable if they meet the Plan of care established for the member.)
- Five days of occasional respite care during a 30-day period

- Hospice Services
  - Physician services by a member of the Hospice interdisciplinary team
  - Nursing care provided by, or under the supervision of, a registered nurse
  - Medical social services by a licensed social worker, provided under the direction of a Physician
  - Counseling services to the member and to caregivers, when care is provided at home
  - BCBSM-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the member)
  - BCBSM-approved durable medical equipment furnished by the Hospice program for use in a member's home
  - Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the member's daily activities and basic functional skills
  - Bereavement counseling for the family after the member's death

  Hospice services are limited to a maximum amount. That amount is reviewed and adjusted from time to time. Once you reach the maximum, Hospice benefits will still be covered under the Case Management program. Please call us for information about the current maximum amount.

3. Professional Services provided by the attending Physician to make the member comfortable and to manage the terminal illness and related conditions

Note: The Plan does not pay for Physician services from a member of the Hospice interdisciplinary team.

Professional services for Hospice care are limited to a maximum amount. This amount is determined by BCBSM and reviewed at times. Once you reach the maximum, professional services will still be covered under the Case Management program. Please call us for information about the current maximum amount. This amount is separate from, and not included in, the limit for the Hospice program services described above.

How to Cancel Hospice Care Services

Hospice care services may be canceled at any time by the member or his or her representative. Simply submit a written statement to the Hospice. When the services are canceled, regular Blue Cross Blue Shield coverage will be reinstated.

How to Reinstate Hospice Care Services

Hospice care services may be reinstated at any time. The member is reinstated for any remaining period for which he or she is eligible.

The Plan does not pay for services:

- Other than those furnished by the Hospice program. (Remember, the services covered are those provided primarily in connection with the condition causing the member's terminal illness.)
- Of a Hospice program other than the one designated by the member. (If the designated program arranges for the member to receive the services of another Hospice program, the services are covered.)
- That are not part of the Plan of care established by the Hospice program for the member

Hospital Services

Locations: The following services are payable in a participating Hospital

The Plan pays for:

1. Inpatient Hospital services:
    - Medical care by Hospital personnel while you are receiving inpatient services.
    - Semiprivate room
    - Nursing services
    - Meals, including special diets
    - Services provided in a special care unit, such as intensive care
    - Oxygen and other therapeutic gases and their administration
    - Inhalation therapy
    - Electroconvulsive Treatment (ECT)
    - Pulmonary function evaluation
    - Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration
    - Hyperbaric oxygenation (therapy given in a pressure chamber)
2. Outpatient Hospital services: If a service is payable as an inpatient service, it is also payable as an outpatient service. (Exceptions are services related to inpatient room, board, and inhalation therapy).

The Plan does not pay for**:**

1. Coverage is excluded for Temporary Benefits for Hospital Services
2. The standard benefit and reimbursement policies for non-participating facilities apply.

Infusion Therapy

Locations: The Plan pays for infusion therapy services in:

1. A participating ambulatory infusion center
2. A member's home
3. An office
4. A participating Hospital

To be eligible for infusion therapy services, your condition must be such that infusion therapy is:

1. Prescribed a Physician to manage an incurable or chronic condition or treat a condition that requires acute care. For home infusion therapy, the condition must be able to be safely managed in the home
2. Medically Necessary
3. Given by a participating infusion therapy provider

The Plan pays for:

1. Drugs required for infusion therapy. Since specialty pharmaceuticals may be used in infusion therapy, please see the Prior Authorization for Specialty Pharmaceuticals requirement described on page 78.

2. Nursing services needed to administer infusion therapy and treat infusion therapy-related wound care

Note: Nursing services must meet BCBSM guidelines to be covered.

3. Durable medical equipment, medical supplies and solutions needed for infusion therapy

The Plan does not pay for services rendered by nonparticipating infusion therapy providers.

Note: Prior authorization may be required for these services. Your in-network provider is responsible for obtaining approval. For a more detailed explanation, see *Prior Authorization for Specialty Pharmaceuticals* in the *Prescription Drugs* section.

Long-Term Acute Care Hospital Services

Locations: The Plan pays for services provided in a participating Long-Term Acute Care Hospital (LTACH).

The Plan pays for: The same services in a participating LTACH that the Plan would pay for in a participating Hospital. However, services are covered only if:

1. The LTACH is located in Michigan and participates with BCBSM, except under extenuating circumstances as determined by BCBSM; and

2. The provider must request and receive preapproval for inpatient services

   Note: The LTACH is liable for the care if the inpatient services are not preapproved.

The Plan does not pay for:

1. Services in a nonparticipating LTACH, including Emergency Services, unless BCBSM determines there are extenuating circumstances

2. Inpatient admissions that BCBSM has not preapproved

3. LTACH services if the patient's primary diagnosis is a mental health or substance use disorder condition

Maternity Care

Locations: The Plan pays for facility and professional services for maternity care and related services in:

1. A participating inpatient Hospital setting

2. A participating birthing center

3. An office

Hospital length of stay in connection with Childbirth for the mother and Child will not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Physician or midwife discharges the mother earlier, after consulting the mother. Prior authorization is not required for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs.

The Plan pays for:

1. Obstetrics

2. Covered services provided by a Physician or certified nurse midwife attending the delivery.

3. Pre-natal care, including maternity education provided in a Physician's office as part of a pre-natal visit

4. Vaginal delivery or cesarean section when provided in:

   - A participating Hospital setting
   - A Hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited Hospital, as defined by BCBSM
   - Post-natal care, including a Papanicolaou (PAP) smear during the six-week visit

5. Other Services

6. Covered services provided to the mother's newborn only during the 48 or 96 hours when the newborn has not been enrolled in the Plan. These services include:

   - Newborn examination given by a Physician other than the anesthesiologist or the mother's attending Physician.
   - Routine care during the newborn's eligible Hospital stay
   - Services to treat a newborn's injury, sickness, congenital defects or birth abnormalities.

The Plan does not pay for:

1. Lamaze, parenting or other similar classes

2. Services provided to the newborn if one of the following apply:

   - The newborn's mother is not covered under the Plan on the newborn's date of birth
   - You direct the Plan to not cover the newborn's services

3. Services provided to the newborn occur after the 48 or 96 hours

Medical Supplies

Locations: The Plan pays for medical supplies in:

1. A participating Hospital

2. A participating Hospice

3. A participating outpatient facility

4. A participating skilled nursing facility

5. An office

6. A member's home.

The Plan pays for: Medical supplies and dressings used for the treatment of a specific medical condition, including but not limited to:

1. Gauze, cotton, fabrics, plaster and other materials used in dressings and casts

2. Ostomy sets and accessories

3. Catheterization equipment and urinary sets

The quantity of medical supplies and dressings must be Medically Necessary.

Mental Health Services

Locations: The Plan pays for mental health services subject to the conditions described below, in:

1. A participating Hospital
2. A participating psychiatric residential treatment facility (PRTF)
3. A participating outpatient psychiatric care (OPC) facility.
4. An office

Note: Mental health services that are the equivalent of an office visit are covered as an office visit.

The Plan pays for:

1. Electroconvulsive Therapy (ECT**)** when provided in an inpatient or outpatient Hospital location and administered by, or under the supervision, of a Physician
2. Anesthetics for ECT when administered by, or under the supervision of, a Physician other than the Physician giving the ECT
3. Inpatient Hospital-mental health services when provided by a Physician or by a fully licensed psychologist with Hospital privileges. If the services are provided by a psychologist, they must be prescribed by a Physician:
    - Individual psychotherapeutic treatment
    - Family counseling for members of a patient's family
    - Group psychotherapeutic treatment
    - Psychological testing prescribed or performed by a Physician. The tests must be directly related to the condition for which the patient is admitted or have a full role in rehabilitative or psychiatric treatment programs
    - Inpatient consultations. If a Physician needs help diagnosing or treating a patient's condition, the Plan pays for inpatient consultations. They must be provided by a Physician or fully licensed psychologist who has the skills or knowledge needed for the case.
4. Psychiatric residential treatment that has been preapproved by BCBSM or its representative. Covered services must be provided by a facility that participates with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield Plan (if located outside of Michigan). The Plan pays for**:**
    - Services provided by facility staff
    - Individual psychotherapeutic treatment
    - Family counseling for members of a patient's family
    - Group psychotherapeutic treatment
    - Prescribed drugs given by the facility
5. Psychiatric partial Hospitalization (PHP) treatment program in Hospitals and outpatient psychiatric care facilities that participate with BCBSM and have a PHP program. The Play pays for:
    - Services provided by the Hospital's or facility's staff
    - Ancillary services
    - Prescribed drugs given by the Hospital or facility during the patient's treatment
    - Individual psychotherapeutic treatment
    - Group psychotherapeutic treatment

- Psychological testing

Note: The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.

- Family counseling for members of patient's family

6. Outpatient Psychiatric Care Facility and Office Setting for Mental Health Services in a participating outpatient psychiatric care facility and office setting for mental health services. The Plan pays for:

    - Services provided by the facility's staff
    - Services provided by a Physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider, as determined by BCBSM in an office setting or a participating outpatient psychiatric care facility:
    - Individual psychotherapeutic treatment
    - Family counseling for members of a patient's family
    - Group psychotherapeutic treatment
    - Psychological testing

Note: The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.

- Prescribed drugs given by the facility in connection with treatment
- A partial Hospitalization program as described in the PHP section

<u>The Plan does not pay for</u>:

1. Consultations required by a facility's or program's rules
2. Marital counseling
3. Services provided by a facility located in Michigan that does not participate with BCBSM or by a facility located outside of Michigan that does not participate with its local Blue Cross/Blue Shield Plan
4. Services that are not focused on improving the member's functioning
5. Services that are primarily for the purpose of maintaining long-term gains made by the member while in another treatment program
6. A residential program that is a long-term substitute for a member's lack of available supportive living environment within the community
7. A residential program that serves to protect family members and other individuals in the member's living environment
8. Services or treatment that are cognitive in nature or supplies related to such services or treatment
9. Treatment or supplies that do not meet BCBSM requirements
10. Transitional living centers such as half-way and three-quarter way houses
11. Therapeutic boarding schools
12. Milieu therapies, such as wilderness program, supportive houses or group homes
13. Domiciliary foster care
14. Custodial care

15. Treatment or programs for sex offenders or perpetrators of sexual or physical violence

16. Services to hold or confine a member under chemical influence when the member does not require medical treatment

17. A private room or an apartment

18. Non-medical services including, but not limited to: enrichment programs, dance therapy, art therapy, music therapy, equine therapy, yoga and other movement therapies, ropes courses, guided imagery, consciousness raising, socialization therapy, social outings or preparatory courses or classes. These services may be paid as part of a treatment program but they are not payable separately.

19. Services provided in a skilled nursing facility or through a residential substance abuse treatment program

When you receive mental health or substance use disorder services under a Case Management agreement that you, your provider and a BCBSM case manager have signed, you will pay your in-network cost-share even if the provider is out-of-network and/or does not participate with BCBSM.

Newborn Care

Locations: The Plan pays for facility and professional services for routine newborn care during an eligible Hospital stay in a participating Hospital setting or birthing center.

Hospital length of stay in connection with Childbirth for the mother and Child will not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Physician or midwife discharges the mother earlier, after consulting the mother. Prior authorization is not required for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs.

The Plan pays for:

1. Newborn examination. The exam must be given by a Physician other than the anesthesiologist or the mother's attending Physician.

2. Routine care during the newborn's Hospital stay

The Play does not pay for: Parenting or other similar classes

Occupational Therapy

Locations: The Plan pays for facility and professional occupational therapy services in the following locations subject to the conditions described below:

1. A participating Hospital

Note: Inpatient therapy must be used to treat the condition for which the member is Hospitalized.

2. A participating freestanding outpatient physical therapy facility

3. An office

4. A participating skilled nursing facility

5. A member's home

6. A nursing home, if it's the member's primary residence

The Plan pays for: a maximum of 60 outpatient visits per member per Calendar Year. The 60-visit maximum renews each Calendar Year. It includes all in-network and out-of-network outpatient visits, regardless of location (Hospital, facility, office or home), for:

1. Occupational therapy
2. Physical therapy (includes physical therapy by a chiropractor)
3. Speech and language pathology
4. Chiropractic mechanical traction

If services in a member's home are billed by a professional provider, an independent physical therapist or occupational therapist, they will count toward the visit maximums.

If services in a member's home are billed by a home health care agency, they will not count toward the visit maximums.

Note: Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit (described above).

Occupational therapy must be:

1. Prescribed by a professional provider licensed to prescribe occupational therapy services
2. Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
3. Given by:
    - A Physician (M.D. or D.O.) in an outpatient setting
    - An occupational therapist
    - An occupational therapy assistant under the indirect supervision of an occupational therapist, who cosigns all assessments and patients' progress notes

Note: Both the occupational therapist and the occupational therapy assistant must be certified by the National Board of Occupational Therapy Certification and licensed in the state of Michigan or the state where the care is provided.

- An athletic trainer under the direct supervision of an occupational therapist in an outpatient setting

The Plan does not pay for:

1. More than 60 outpatient visits per member per Calendar Year, whether obtained from an in-network or out-of-network provider.
2. Therapy to treat long-standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without an occupational therapy treatment Plan that guides and helps to monitor the provided therapy.
3. Services of a freestanding facility provided to you while you are an inpatient in a Hospital, skilled nursing facility or residential substance abuse treatment program
4. Services received from a nonparticipating Hospital, nonparticipating freestanding outpatient physical therapy facility, other nonparticipating facilities independent of a Hospital

5. Services received from an independent sports medicine clinic

6. Treatment **solely** to improve cognition (*e.g.*, memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

Note: The Plan may pay for treatment to improve cognition if it is:

- Part of a comprehensive rehabilitation Plan
- Medically Necessary to treat severe deficits in patients who have certain conditions that are identified by BCBSM

7. Recreational therapy

8. Patient education and home programs

Office, Outpatient and Home Medical Care Visits

Locations: The Plan pays for the following when provided by a Physician or eligible professional provider when Medically Necessary:

1. Office visits, including urgent care visits, office consultations, online visits, and retail health clinic visits

2. Outpatient visits

3. Home medical care visits

The following are examples of services that will not require any Copayments when provided in an in-network Physician's office:

1. Prenatal and postnatal care

2. Allergy testing and therapy

3. Therapeutic injections

4. Presurgical consultations

We do not pay for routine eye exams and hearing tests, **unless** they are related to an illness, injury or pregnancy.

Mental Health and Substance Use Disorder Treatment Services

Some mental health and substance use disorder services are considered by BCBSM to be the same as an office visit. When a mental health or substance use disorder service is considered by BCBSM to be the same as an office visit, the Plan will consider the claim an office visit.

Online

The Plan covers all Medically Necessary online and telehealth visits with a professional provider in and out-of-network without cost-sharing but subject to usual and customary charge limits.

Note: Online visits by an online visit vendor will not be covered.

The online visit must allow the patient to interact with the professional provider in real time. Treatment and consultation recommendations made online, including issuing a prescription, are to be held to the same standards of appropriate practice as those in traditional settings.

Note: Not all services delivered via the internet are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the same cost share as services rendered in an office setting.

Online visits must meet BCBSM's standards for an Evaluation and Management visit.

The online visit provider must be licensed in the state where the patient is located during the online visit.

Online visits **do not** include:

1. Reporting of normal test results
2. Provision of educational materials
3. Handling of administrative issues, such as registration, scheduling of appointments, or updating billing information

Oncology Clinical Trials

Locations: The Plan pays for services performed in a Designated Cancer Center.

Benefits for specified oncology Clinical Trials provide coverage for:

1. Preapproved, specified bone marrow and peripheral blood stem cell transplants and their related services
2. FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer
3. All stages of ovarian cancer when they are provided pursuant to an approved phase II or III Clinical Trial

Mandatory Preapproval

All services, admissions or lengths of stay for the services below must be **preapproved** by BCBSM.

The Designated Cancer Center must submit its written request for preapproval to:

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 1519
600 Lafayette East
Detroit, MI 48226
Fax: (866) 752-5769

The Plan pays for:

1. Antineoplastic drugs.
2. Immunizations against infection during the first 24 months after a transplant as recommended by the ACIP (Advisory Committee on Immunization Practices).
3. Autologous Transplants
4. Infusion of colony stimulating growth factors
5. Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
6. Purging or positive stem cell selection of bone marrow or peripheral blood stem cells

7. High-dose chemotherapy and/or total body irradiation

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

9. Hospitalization

10. Allogeneic Transplants

11. Blood tests to evaluate donors (if not covered by the potential donor's insurance)

12. 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 and the transplant is preapproved.

13. Infusion of colony stimulating growth factors

14. Harvesting and storage (both covered even if it is not covered by the donor's insurance) of the donor's:

    - Bone marrow
    - Peripheral blood stem cell (including peripheral blood stem cell pheresis)
    - Umbilical cord blood

Note: The recipient of harvested material must be a Covered Individual.

15. High-dose chemotherapy and/or total body irradiation

16. Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood

17. T cell depleted infusion

18. Donor lymphocyte infusion

19. Hospitalization

20. Travel and Lodging

    We will pay up to a total of $5,000 for your travel and lodging expenses. They must be directly related to preapproved services rendered during an Approved Clinical Trial. The expenses must be incurred during the period that begins with the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.

    We will pay the expenses of an adult patient and another person. If the patient is under the age of 18, the Plan pays for the expenses of the patient and two additional people. The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:

    - $60 per day for travel
    - $50 per day for lodging

Note: These daily allowances may be adjusted from time to time. Please call us to find out the current maximums.

<u>The Plan does not pay for</u>:

1. An admission to a designated center or a length of stay at a designated center that has not been preapproved

2. Services that have not been preapproved

3. Services that are not Medically Necessary

4. Services rendered at a nonDesignated Cancer Center

5. Services provided by persons or entities that are not legally qualified or licensed to provide such services

6. Donor services for a transplant recipient who is not a Covered Individual

7. Services rendered to a donor when the donor's health care coverage will pay for such services

8. The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year

9. More than two single transplants per member for the same condition

10. Non-health care related services and/or research management (such as administrative costs)

11. Transplants performed at a center that is not a Designated Cancer Center or its affiliate

12. Search of an international donor registry

13. Experimental Treatment

14. Items or services that are normally covered by other funding sources (*e.g.*, investigational drugs funded by a drug company)

15. Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to:

    - Alcoholic beverages
    - Car maintenance
    - Clothing, toiletries
    - Dry cleaning or laundry services
    - Flowers, toys, gifts, greeting cards, stationary, stamps, mail/UPS services
    - Furniture rental
    - Household products
    - Household utilities (including cellular telephones
    - Internet connection and entertainment (such as cable television, books, magazines and movie rentals)
    - Kennel fees
    - Lost wages
    - Maids, babysitters or day care services
    - Mortgage or rent payments
    - Reimbursement of food stamps
    - Security deposits, cash advances
    - Services provided by family members
    - Tips

16. Any other services, admissions or length of stay related to any of the above exclusions

The limitations and exclusions listed elsewhere in the Plan documents, also apply to this benefit.

Optometrist Services

<u>The Plan pays for</u>:

1. Services performed by a licensed optometrist within the scope of his or her license and subject to the conditions described below.

2. The optometrist must provide the covered services within the state of Michigan.

3. The optometrist must be:

    - Licensed in the state of Michigan
    - Certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents

If you get services from an optometrist who does not participate in BCBSM's vision program, they will be treated as services of a nonparticipating provider.

Outpatient Diabetes Management Program

All cost-sharing for diabetes self-management training is waived when performed by an in-network provider.

Locations: The Plan pays for services provided in a home or (for training) in a group setting subject to the conditions described below.

The Plan pays for:

Selected services and medical supplies to treat and control diabetes when Medically Necessary and prescribed by an M.D. or D.O., including:

1. Blood glucose monitors
2. Blood glucose monitors for the legally blind
3. Insulin pumps
4. Test strips for glucose monitors
5. Visual reading and urine test strips
6. Lancets
7. Spring-powered lancet devices
8. Syringes
9. Insulin
10. Medical supplies required for the use of an insulin pump
11. Nonexperimental drugs to control blood sugar
12. Medication prescribed by a Doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes
13. Diabetes self-management training conducted in a group setting, whenever practicable, if:

    - Self-management training is considered Medically Necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive Plan of care to ensure therapy compliance or to provide necessary skills and knowledge
    - Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
    - The provider of self-management training must be:

- Certified to receive Medicare or Medicaid reimbursement or
- Certified by the Michigan Department of Community Health.

You pay no cost-sharing for training from an in-network provider.

Pain Management

Locations: The Plan pays for services to manage pain, subject to the conditions described below, in a participating Hospital, participating outpatient facility, or office.

The Plan pays for:

1. Covered services and devices for pain management when Medically Necessary as documented by a Physician.

2. Covered services performed by a certified registered nurse anesthetist.

The Plan does not pay for: Services and devices for pain management provided by a nonparticipating Hospital or facility.

Physical Therapy

Locations. The Plan pays for physical therapy services in:

1. A participating Hospital

Note: Inpatient therapy must be used to treat the condition for which the member is Hospitalized.

2. A participating skilled nursing facility

3. A participating freestanding outpatient physical therapy facility

Note: For freestanding facilities, the Plan pays the facility directly for the service, not the individual provider who rendered the service.

4. An office

5. The member's home

6. A nursing home, if it is the member's primary residence

The Plan pays for: A maximum of 60 outpatient visits per member per Calendar Year. The 60-visit maximum renews each Calendar Year. It includes all in-network and out-of-network outpatient visits, regardless of location (Hospital, facility, office or home), for:

1. Occupational therapy

2. Physical therapy (includes physical therapy by a chiropractor)

3. Speech and language pathology

4. Chiropractic mechanical traction

If services in a member's home are billed by a professional provider, an independent physical therapist or occupational therapist, they will count toward the visit maximums.

If services in a member's home are billed by a home health care agency, they will not count toward the visit maximums.

Note: Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit (described above)

Physical therapy must be**:**

1. Prescribed by a professional provider licensed to prescribe it, unless it is performed by a chiropractor (see page 52)

2. Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning

3. Given by the approved providers in the locations listed below:

Locations	Providers
• A Hospital, inpatient or outpatient • A skilled nursing facility • A freestanding outpatient physical therapy facility • A provider's office • A member's home • A nursing home if it is the member's primary residence	• A professional provider (M.D., D.O. or a podiatrist) • A dentist or optometrist • A chiropractor • A physical therapist, physical therapist assistant, or athletic trainer • A Physician's assistant • A certified nurse practitioner

Not all of the providers listed above can perform physical therapy in all of these locations. And some of these providers must be supervised by other types of providers for their services to be covered. Please call Customer Service if you have questions about where physical therapy can be provided or who can provide it.

The Plan does not pay for:

1. More than 60 outpatient visits per member per Calendar Year, whether obtained from an in-network or out-of-network provider.

2. Services received from a nonparticipating Hospital, freestanding outpatient physical therapy facility, skilled nursing facility, or any other facility independent of a Hospital

3. Services received from an independent sports medicine clinic

4. Services of a freestanding facility provided to you in the home or while you are an inpatient in a Hospital, skilled nursing facility or residential substance abuse treatment program

5. Therapy to treat long-standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a physical therapy treatment Plan that guides and helps to monitor the provided therapy.

6. Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program

7. Treatment solely to improve cognition (*e.g.*, memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought without a physical therapy treatment Plan that guides and helps to monitor the provided therapy

Note: The Plan may pay for treatment to improve cognition if it is:

- Part of a comprehensive rehabilitation Plan, and
- Medically Necessary to treat severe deficits in patients who have certain conditions that are identified by BCBSM

8. Patient education and home programs (such as home exercise programs)

9. Sports medicine for purposes such as prevention of injuries or for conditioning

10. Recreational therapy

Prescription Drugs

Locations: The Plan pays for Medically Necessary prescription drugs. They can be given in a participating Hospital or in other approved locations. Prescription drugs are subject to the conditions described below.

We pay for:

1. Drugs Received in a Hospital (Inpatient or Outpatient). We pay for prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) administered as part of the treatment for the disease, condition or injury that are:

   - Labeled FDA-approved as defined under the amended Federal Food, Drug and Cosmetic Act and
   - Used during an inpatient Hospital stay or dispensed when part of covered outpatient services

2. Drugs Received in Other Locations. Drugs are also payable:

   - In a participating freestanding Ambulatory Surgery Facility when directly related to surgery
   - In a participating freestanding ESRD facility in conjunction with dialysis services
   - In a participating skilled nursing facility
   - As part of home health services when services are provided by a participating Hospital
   - When required for infusion therapy
   - In a participating Hospice for the comfort of the patient
   - In a participating residential substance abuse treatment facility or as part of a participating outpatient substance treatment program

3. Drugs Administered by a Physician:

   - Injectable drugs or biologicals, and their administration. The drugs or biologicals must be:
     - FDA approved,
     - Ordered or supplied by a Physician, and
     - Administered by the Physician or under the Physician's supervision.
   - Specialty pharmaceuticals given to you by an in-network or participating provider. The Plan pays for:
     - Drugs and their administration when ordered and billed by a Physician, or
     - Drugs billed by the specialty pharmacy
     - Physician's administration of the drug

Note: Self-injected drugs are not covered

- Hemophilia medication when you get it from:

- In-Network Providers
- Out-of-Network Providers
- Participating providers
- Nonparticipating providers

- Supplies for the infusion of the hemophilia factor product. If you buy them from a participating provider, the Plan pays the provider directly. If you buy them from a nonparticipating provider, the Plan pays you and you need to pay the nonparticipating provider.

Note: The Plan does not pay for hemophilia medication and supplies dispensed under the prescription drug program (see page 108).

Prior Authorization for Specialty Pharmaceuticals

Prior authorization is required for select specialty drugs that will be administered in locations that have been determined by BCBSM. These locations include, but not limited to:

1. Office
2. Clinic
3. Home
4. Outpatient Facilities

The Plan requires prior authorization for specialty drugs for in-state and out-of-state services. Your Physician should contact BCBSM and follow the utilization management processes to get prior authorization for your specialty drug.

Request for Drugs Not on BCBSM's Drug List

If your prescription drug coverage is limited to an approved drug list, BCBSM must approve coverage of a prescription drug not on the list ***before*** it is dispensed. If you or your prescriber do not obtain approval before the drug is dispensed, the drug will not be covered.

To request BCBSM's approval, you, your designee, or the prescriber or the prescriber's designee should contact us and follow the exception request process.

For expedited requests due to exigent circumstances:

The person making the request of will be notified of the decision (either approval or denial) within 24 hours after all of the information needed to make a determination is received.

For requests that are not due to exigent circumstances:

If your request is not an exigent circumstance, you will be notified of the decision within 72 hours after all of the information needed to make a determination is received.

If the exception request is approved, you will have to pay your Deductibles, Coinsurances or Copayments.

Note: Only FDA-approved drugs are eligible for an exception. Of those drugs, BCBSM will only approve the drugs that meet the clinical criteria and are effective in treating your condition.

To learn more about this process, visit www.bcbsm.com or call the Customer Service number on the back of your card.

Preventive Care Services

The Plan pays for all preventive and immunization services required under the ACA. The services required under ACA change from time- to-time, so to see a current list, contact the Plan Office or visit https://www.healthcare.gov/coverage/preventive-care-benefits/.

Most preventive care services are covered only when performed by an in-network provider. But, colonoscopies, mammograms, triglyceride screening, and women's contraceptive services are covered whether they are done by an in-network or an out-of-network provider.

Locations: The Plan pays for facility and professional services for preventive care in the following locations subject to the conditions described below:

1. A participating Hospital (inpatient or outpatient)

2. A participating facility (*e.g.*, an ambulatory surgery center)

3. A professional provider's office

Independent laboratory to analyze a test are also covered.

The Plan pays for:

1. Preventive care services recommended by the United States Preventive Services Task Force with an A or B recommendation, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration

2. Related reading and interpretation of your test results. If an in-network provider does a covered preventive test, and an out-of-network provider reads and interprets the results, the claim from the out-of-network provider will be paid as if it were an in-network claim.

3. One health maintenance exam per member, per Calendar Year; this is a full history and physical exam. It includes taking your blood pressure, looking for skin malignancies, a breast exam, a testicular exam, a rectal exam and health counseling about any potential risk factors you may encounter.

4. One routine flexible sigmoidoscopy examination per member, per Calendar Year.

5. One routine gynecological examination per member, per Calendar Year.

6. Laboratory and pathology services for one routine Pap smear per member, per Calendar Year, when prescribed by a Physician.

7. One routine mammogram and the related reading, once per member per Calendar Year to screen for breast cancer.

8. Fecal Occult Blood Screening

9. One fecal occult blood screening per member, per Calendar Year to detect blood in the feces or stool.

10. Well-Baby and Child Care Visits

    - Eight visits for Children from birth through 12 months
    - Six visits for Children 13 months through 23 months
    - Six visits for Children 24 months through 35 months
    - Two visits for Children 36 months through 47 months

- Childcare visits after 47 months are limited to one per member, per Calendar Year under your health maintenance exam benefit.

11. Childhood and adult immunizations.

12. One routine prostate specific antigen screening per member, per Calendar Year.

13. Routine Laboratory and Radiology Services. The following services once per member, per Calendar Year, when performed as routine screening:

    - Chemical profile
    - Complete blood count or any of its components
    - Urinalysis
    - Chest X-ray
    - EKG
    - Cholesterol testing
    - Triglyceride screening (screening is covered at 100% regardless of diagnosis or whether performed by an in-network or out-of-network provider)

14. Hospital and Physician benefits for colonoscopy services are payable at 100 percent of the BCBSM Approved Amount as follows:

    - One routine screening colonoscopy once per member per Calendar Year. It can be done by an in-network or an out-of-network provider.
    - If you need another colonoscopy done in the same Calendar Year, you will have to pay your cost-share. It can be done by an in-network or out-of-network provider.

15. Morbid Obesity Weight Management. For a member with a BMI of 30 or above, 26 visits per member per Calendar Year are covered. Visits can include nutritional counseling, such as dietician services, billed by a Physician or other provider recognized by BCBSM.

16. Tobacco cessation programs, including screening, counseling and select prescription drugs to help you stop smoking.

17. Women's Preventive Care Contraceptive Services

    - Hospital, facility, and Physician's services for voluntary sterilizations for females.
    - Contraceptive counseling services provided to females during an annual physical or at a separate counseling session.
    - Contraceptive devices that need a prescription by a Physician, certified nurse midwife, or other legally authorized professional provider, including insertion and removal.
    - Contraceptive injections given by a Physician, certified nurse midwife, or other legally authorized professional provider, including the injected medication if the provider supplies it. If a Physician, certified nurse midwife, or other legally authorized professional provider injects you with a contraceptive medication you bought from a pharmacy, only services of the provider for the injection are covered under this benefit.

18. BRCA (counseling about genetic testing) – for women at higher risk

The Plan does not pay for: screening and preventive services that are not listed in this SPD or not required to be covered under ACA.

Private Duty Nursing Services

Locations: The Plan pays for private duty nursing services in your home or in a participating Hospital subject to the conditions described below.

The Plan pays for: Skilled care given by a private duty nurse if:

1. The patient's medical condition requires 24-hour care

2. The patient requires Medically Necessary skilled care for a portion of the 24-hour period

3. The skilled care (for example, ventilator care) is given by a professional registered nurse or licensed practical nurse

4. The skilled care is given in a Hospital because the Hospital lacks intensive or cardiac care units or has no space in such units

5. The skilled care is provided by a nurse who is not related to, or living with, the patient

Private duty nurses may require you to pay for services at the time they are provided. Submit an itemized statement to us for services. **All progress notes must be submitted with the claim form**. The Plan will pay the Approved Amount to you.

The Plan does not pay for: custodial care

Professional Services

The services listed in this section are in addition to all of the other services listed in this SPD. The services in this section are also payable to a professional provider.

1. Covered services that are provided by a certified nurse practitioner.

2. Inpatient and Outpatient Consultations: If a Physician needs help diagnosing or treating a patient's condition, the Plan covers inpatient and outpatient consultations. The consultations must be provided by a Physician or professional provider who has the skills or knowledge needed for the case.

   Staff consultations required by a facility's or program's rules are not covered.

Note: When you have a consultation appointment in an in-network Physician's office, you will need to pay your Copayment.

3. Therapeutic injections

Prosthetic and Orthotic Devices

Locations: The Plan pays for prosthetic and orthotic devices while you are in a participating Hospital or for use outside of the Hospital.

The Plan pays for:

1. Prosthetic and orthotic devices:

   - Prescribed by a Physician or certified nurse practitioner
   - And permanently implanted in the body
   - Or used externally, such as an artificial eye, leg, arm

2. The prescription must include a description of the equipment and the reason for the need or the diagnosis. Covered services include:

   - The cost of purchasing, replacing, obtaining, developing and fitting the basic device and any Medically Necessary special features
   - Cost of purchasing or replacing the device
   - Cost of developing and fitting the basic device

- Any Medically Necessary special features
- Repairs, limited to the cost of a new device

3. We will pay for the cost to replace a prosthetic device due to:

   - A change in the patient's condition
   - Damage to the device so that it cannot be restored
   - Loss of the device

4. One pair of orthotic shoe inserts per lifetime. Shoe inserts are not subject to the provider restrictions or the ABC accreditation requirement noted below.

Coverage Guidelines

The Plan covers external prosthetic and orthotic devices that are payable by Medicare Part B. They are covered as of the date they were bought or rented. In some cases, BCBSM guidelines may be different from those of Medicare Part B. Please call your local Customer Service center for specific coverage information.

Generally, to be covered, custom-made devices must be furnished by a fully accredited provider, with BCBSM approval, conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC). You may call BCBSM to confirm a provider's status.

Prosthetic and orthotic suppliers may include:

1. M.D.s, D.O.s,
2. Podiatrists,
3. Prosthetists
4. Orthotists

All suppliers must meet BCBSM qualification standards.

Note: An optometrist who is also a prosthetist may only provide ocular prostheses.

Provider Limitations

If a provider is participating with BCBSM but is not accredited by ABC, only the following devices are covered:

1. External breast prostheses following a mastectomy which include:

   - Two post-surgical brassieres and
   - Two brassieres in any 12-month period thereafter

   Additional brassieres are covered if they are required because of significant change in body weight or for hygienic reasons

2. Prefabricated custom-fitted orthotic devices
3. Artificial eyes, ears, noses and larynxes
4. Ostomy sets and accessories, catheterization equipment and urinary sets
5. Prescription eyeglasses or contacts lenses after cataract surgery; the surgery can be for any disease of the eye or to replace a missing organic lens. Optometrists may provide these lenses
6. External cardiac pacemakers

7. Therapeutic shoes, shoe modifications and inserts for persons with diabetes

8. Maxillofacial prostheses that have been approved by BCBSM. Dentists may provide you with these devices.

9. If you have an urgent need for an item that is not custom-made (*e.g.*, wrist braces, ankle braces, or shoulder immobilizers), the Plan will pay for the item to be provided by an M.D., D.O., or podiatrist. Please call your local Customer Service center for information on which devices are covered.

The Plan does not pay for:

1. Hair prostheses such as wigs, hair pieces, hair implants, etc.

2. Spare prosthetic devices

3. Routine maintenance of a prosthetic device

4. Experimental prosthetic devices

5. Prosthetic devices ordered or purchased before the effective date of this coverage under this certificate

6. Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets

7. Hearing aids

Radiology Services

Locations: The Plan pays for Hospital, facility and Physician diagnostic and therapeutic radiology services in a participating Hospital, a participating facility or an office.

The Plan pays for:

1. Diagnostic Radiology Services, including facility and Physician radiology services used to diagnose disease, illness, pregnancy or injury. The services must be prescribed or provided by your Physician or by another Physician if agreed on by your Physician:

    - X-rays
    - Radioactive isotope studies and use of radium
    - Ultrasound
    - Computerized axial tomography (CAT) scans (Prior authorization required)
    - Magnetic resonance imaging (MRI) (Prior authorization required)
    - Positron emission tomography (PET) scans (Prior authorization required)
    - Medically Necessary mammography

2. Therapeutic Radiology Services, including facility and Physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be prescribed or provided by your Physician or, by another Physician if agreed on by your Physician.

The Plan does not pay for: procedures not directly related and necessary to diagnose a disease, illness, pregnancy or injury (such as an ultrasound solely to determine the sex of the fetus).

Skilled Nursing Facility Services

Locations: The Plan pays for facility and professional services in a skilled nursing facility when the skilled nursing facility **participates** with BCBSM and the admission is ordered by the patient's attending Physician.

Note: Prior authorization is required for skilled nursing facility care. The Plan requires written confirmation from your Physician that **skilled care** is needed.

Length of Stay: The Plan covers only the period that is necessary for the proper care and treatment of the patient. The maximum length of stay is 120 days per member, per Calendar Year.

The Plan pays for:

1. A semiprivate room, including general nursing service, meals and special diets
2. Special treatment rooms
3. Laboratory examinations
4. Oxygen and other gas therapy
5. Drugs, biologicals and solutions
6. Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
7. Durable medical equipment used in the facility or outside the facility when rented or purchased from the skilled nursing facility
8. Physician services (up to two visits per week)
9. Physical therapy (Page 75), speech and language pathology services (Page 85) or occupational therapy (Page 68) when Medically Necessary

Note: The physical therapy, occupational therapy, or speech and language pathology services that are done in a skilled nursing facility are inpatient benefits. The 60-visit benefit maximums apply only when these services are provided on an outpatient basis.

The Plan does not pay for:

1. Custodial care
2. Care for senility or developmental disability
3. Care for substance use disorder
4. Care for mental illness (other than for short-term nervous and mental conditions to which the 120-day maximum applies)
5. Care provided by a nonparticipating skilled nursing facility

Special Medical Foods for Inborn Errors of Metabolism

The Plan pays for: special medical foods for the dietary treatment of inborn errors of metabolism. These foods must be prescribed by a Physician after a complete medical evaluation of the patient's condition has been done.

The cost of special medical foods must be higher than the cost of foods or items that are not special medical foods

Medical documentation must support the diagnosis of a covered condition that requires special medical foods

Note: BCBSM determines which conditions are payable

To be paid, you must submit the prescription from the treating Physician along with receipts for your special medical food purchases to BCBSM. Mail your receipts along with a "Member Application for Payment Consideration" to:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd
Imaging & Support Services, MC 0010
Detroit, MI 48226-2998

You can obtain the above-mentioned form by visiting www.**bcbsm.com.** Click on "Member Forms" under the "Member Secured Services" tab. If you cannot access the Web site or you have trouble finding what you need, please contact Customer Service at one of the telephone numbers listed in Section 9.

The Plan does not pay for:

1. Nutritional products, supplements, medical foods or any other items provided to treat medical conditions that are not related to the treatment of inborn errors of metabolism

Note: BCBSM determines what conditions are related to inborn errors of metabolism. Diabetes mellitus is excluded as a payable diagnosis for this benefit

2. Foods used by patients with inborn errors of metabolism that are not special medical foods, as defined by the Plan documents

3. Nutritional products, supplements or foods used for the patient's convenience or for weight reduction programs

Speech and Language Pathology

Locations: The Plan pays for facility and professional speech and language pathology services:

1. A participating Hospital (inpatient or outpatient)

Note: Inpatient therapy given in a Hospital must be used to treat the condition for which the member is Hospitalized.

2. A participating freestanding outpatient physical therapy facility

Note: The Plan pays freestanding facilities for physical therapy services. The Plan does not pay the person who provided the services.

3. An office

4. A member's home

5. A nursing home, if it's the member's primary residence

6. A participating skilled nursing facility

The Plan pays for:

We pay for a maximum of 60 outpatient visits per member Calendar Year whether obtained from an in-network or out-of-network provider. The 60-visit maximum renews each Calendar Year. It includes all in-network and out-of-network outpatient visits, regardless of location (Hospital, facility, office or home), for:

1. Occupational therapy

2. Physical therapy (includes physical therapy by a chiropractor)

3. Speech and language pathology

4. Chiropractic mechanical traction

If services in a member's home are billed by a professional provider or independent therapist, they will count toward the visit maximums.

If services in a member's home are billed by a home health care agency, they will not count toward the visit maximums.

Note: Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit (described above).

Speech and language pathology services must be:

1. Prescribed by a professional provider licensed to prescribe speech and language pathology services

2. Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning

3. Given by:

    - A speech-language pathologist certified by the American Speech-Language-Hearing Association or
    - By one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

Note: When a speech-language pathologist has completed the work for their master's degree, they begin a clinical fellowship for a year. In that year, their work is supervised by a certified speech-language pathologist.

The Plan does not pay for:

1. Treatment **solely** to improve cognition (*e.g.*, memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

Note: The Plan may pay for treatment to improve cognition if the treatment is part of a comprehensive rehabilitation Plan. The treatment must be necessary to treat severe speech deficits language and/or voice deficits. This treatment is for patients with certain conditions that have been identified by BCBSM.

2. Recreational therapy

3. Patient education and home programs

4. Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

Note: A BCBSM medical consultant may decide that speech and language pathology services can be used to treat chronic, developmental or congenital conditions for some Children with severe developmental speech disabilities.

5. Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a speech and language pathology treatment Plan that guides and helps to monitor the provided therapy

6. Services provided by speech-language pathology assistants or therapy aides.

7. Services received from a nonparticipating freestanding outpatient physical therapy facility or a nonparticipating skilled nursing facility or from other nonparticipating facilities independent of a Hospital.

8. More than 60 outpatient visits per member per Calendar Year.

9. Services of a freestanding facility provided to you in the home or while you are an inpatient in a Hospital, skilled nursing facility or residential substance abuse treatment program

Substance Use Disorder Treatment Services

Locations: The Plan will pay for substance use disorder treatment services in:

1. A participating Hospital
2. A participating residential or outpatient substance abuse rehabilitation facility
3. A participating outpatient psychiatric care (OPC) facility
4. An office

Note: Substance use disorder treatment services that are the equivalent of an office visit are covered as an office visit. Please see "Office, Outpatient and Home Medical Care Visits" on Page 70.

Inpatient Hospital Substance Use Disorder Treatment Services

The Plan pays for: Acute detoxification

Note: Acute detoxification is covered and paid as a medical service.

Services must be provided in a participating Hospital.

Prior authorization required for substance use disorder treatment.

Residential and Outpatient Substance Abuse Rehabilitation Facility Treatment Services

The Plan pays for substance use disorder treatment in a:

1. A participating residential substance abuse rehabilitation facility or
2. A participating outpatient Hospital
3. A participating outpatient substance abuse rehabilitation facility.

The following criteria must be met:

1. A Physician must find that you need substance use disorder treatment and note in the medical record if the treatment should be residential or outpatient.
2. A Physician must:
   - Provide an initial physical exam
   - Diagnose the patient with a substance use disorder condition
   - Certify that the required treatment can be given in a residential or an outpatient substance abuse rehabilitation facility
   - Provide and supervise your care during subacute detoxification and
   - Provide follow-up care during rehabilitation
3. The services need to be Medically Necessary to treat your condition.
4. The services in a residential substance abuse rehabilitation facility must be preapproved by BCBSM.

The Plan pays for the following services provided and billed by an approved program:

1. Laboratory services
2. Diagnostic services
3. Supplies and equipment used for subacute detoxification or rehabilitation
4. Professional and trained staff services and program services necessary for care and treatment
5. Individual and group therapy or counseling
6. Therapy or counseling for family members
7. Psychological testing
8. Outpatient substance use disorder services for the treatment of tobacco dependence

The Plan also pays for the following in a residential substance abuse treatment program:

1. Room and board
2. General nursing services
3. Drugs, biologicals and solutions used in the facility

The Plan also pays for the following in an outpatient substance abuse treatment program: Drugs, biologicals and solutions used in the program, including drugs taken home

The Plan does not pay for:

1. Dispensing methadone or testing of urine specimens unless you are receiving therapy, counseling or psychological testing while in the program
2. Diversional therapy
3. Services provided beyond the period necessary for care and treatment
4. Treatment, or supplies that do not meet BCBSM requirements

<u>Outpatient Psychiatric Care Facility and Office Setting for Substance Use Disorder Services</u>

The Plan pays for:

1. Services provided by the facility's staff
2. Services provided by a Physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider as determined by BCBSM
3. Prescribed drugs given by the facility in connection with treatment

The Plan only pays for services in a participating outpatient psychiatric care (OPC) facility and office setting.

The Plan does not pay for:

1. Services provided in a skilled nursing facility or through a residential substance abuse treatment program

2. Marital counseling

3. Consultations required by a facility or program's rule

4. Services provided by a nonparticipating outpatient psychiatric care facility

Surgery Services

Locations: The Plan pays for Hospital, facility and professional services for surgery in a participating Hospital, as an inpatient or an outpatient, a participating freestanding Ambulatory Surgery Facility, or an office

The Plan pays for:

1. Presurgical Consultations

    - If your Physician tells you that you need surgery, you may choose to have a presurgical consultation with another Physician. The consulting Physician must be an MD, DO, podiatrist or an oral surgeon.
    - The consultation will be paid if the surgery you plan to have is covered under this certificate and will be done in a covered location (see above).
    - You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:
        - Second opinion — a consultation to confirm the need for surgery
        - Third opinion — allowed if the second opinion differs from the initial proposal for surgery
        - Nonsurgical opinion — given to determine your medical tolerance for the proposed surgery

2. Surgery

    - Physician's surgical fee
    - Medical care provided by the surgeon before and after surgery while the patient is in the Hospital
    - Visits to the attending Physician for the usual care before and after surgery
    - Operating room services, including delivery and surgical treatment rooms
    - Sterilization (whether or not Medically Necessary)

Note: As part of your preventive services, the Plan covers voluntary sterilization for females.

- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration related to surgery
- Cosmetic surgery is only payable when necessary for:
    - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
    - Correction of deformities resulting from cancer surgery including reconstructive surgery after a mastectomy
    - Conditions caused by accidental injuries, and
    - Traumatic scars

Note: The Plan does not pay for cosmetic surgery and related services that are only to improve your personal appearance.

3. Dental surgery is only payable for multiple extractions or removal of unerupted teeth or alveoloplasty when:

    - A Hospitalized patient has a dental condition that is adversely affecting a medical condition, and
    - Treatment of the dental condition is expected to improve the medical condition

For surgery and treatment related to the treatment of temporomandibular joint (jaw joint) dysfunction (TMJ), see page 54.

4. Multiple surgeries performed on the same day by the same Physician are payable according to national standards recognized by BCBSM.

5. Technical surgical assistance (TSA): In some cases, a surgeon will need another Physician to give them technical assistance. The Plan pays the Approved Amount for TSA, according to BCBSM guidelines. The surgery can be done in a:

   - Participating Hospital (inpatient or outpatient)
   - Participating Ambulatory Surgery Facility

   A list of TSA surgeries that the Plan covers is available from your local Customer Service center.

   The Plan does not pay for TSA:

   - When services of interns, residents or other Physicians employed by the Hospital are available at the time of surgery or
   - When services are provided in a location other than a Hospital or Ambulatory Surgery Facility

Freestanding Ambulatory Surgery Facility Services

The Plan pays for facility services in a BCBSM participating ambulatory surgery center. The services must be Medically Necessary. You must be a patient of a licensed MD, DO, podiatrist or oral surgeon to be admitted to the center. The services must be directly related to the covered surgery.

The following services are payable:

1. Use of Ambulatory Surgery Facility
2. Anesthesia services and materials
3. Recovery room
4. Nursing care by, or under the supervision of, a registered nurse
5. Drugs, biologicals, surgical dressings, supplies, splints and casts directly related to providing surgery
6. Oxygen and other therapeutic gases
7. Skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissue, as well as the cost of processing and storage
8. Administration of blood
9. Routine laboratory services related to the surgery or a concurrent medical condition
10. Radiology services performed on equipment owned by, and performed on the premises of, the facility that are necessary to enhance the surgical service
11. Housekeeping items and services
12. EKGs

The Plan does not pay for: services by a nonparticipating Ambulatory Surgery Facility

Temporary Benefits for Out-of-network Hospital Services

Coverage is excluded for Temporary Benefits for Hospital Services and the standard benefit and reimbursement policies for non-participating facilities apply.

Transplant Services

Locations: Kidney, cornea, skin and bone marrow transplants are payable when performed in a participating Hospital or participating Ambulatory Surgery Facility.

The Plan covers transplants **only** if they are done in a "designated facility".

The Plan pays for:

Organ transplants and bone marrow transplants if the transplant recipient is a BCBSM member. Living donor and recipient transplant services are paid under the recipient's coverage.

1. Services performed to obtain, test, store and transplant the following human tissues and organs:
    - Kidney
    - Cornea
    - Skin
    - Bone marrow (described below)
2. Immunizations against common infectious diseases during the first 24 months after your transplant, following the guidelines of the Advisory Committee on Immunization Practices (ACIP).

Note: The immunization benefit does not apply to cornea and skin transplants.

Bone Marrow Transplants

Bone marrow transplants require preapproval. If you do not get preapproval before you receive the transplant, neither it nor any related services will be covered and you will have to pay all costs.

When they are directly related to:

1. Two tandem transplants
2. Two single transplants
3. A single and a tandem transplant

For each member and for each condition, the Plan covers the following services:

1. Allogeneic Transplants
    - Blood tests on first degree relatives to evaluate them as donors
    - 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 and the transplant is preapproved.
    - Infusion of colony stimulating growth factors
    - Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:

- A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
- Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.)

Note: The Plan covers the donor's harvesting and storage when the recipient is a Covered Individual. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

2. Autologous Transplants

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

Note: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. The Plan pays for up to two tandem transplants or a single and a tandem transplant per patient for this condition.

3. Allogeneic transplants and autologous transplants are covered to treat only certain conditions. Please call the Plan Office or Customer Service for a list of these conditions.

4. Services related to, or for:

- High-dose chemotherapy
- Total body irradiation
- Allogeneic or autologous transplants to treat conditions that are not experimental

The coverage includes the cost of administering the drugs.

<u>The Plan does not pay the following for bone marrow transplants</u>:

1. Services that are not Medically Necessary
2. Services provided in a facility that does not participate with BCBSM
3. Services provided by persons or groups that are not legally qualified or licensed to provide such services
4. Services provided to a transplant recipient who is not a Covered Individual
5. Services provided to a donor when the transplant recipient is not a Covered Individual
6. Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements

7. Expenses related to travel, meals and lodging for donor or recipient

8. An autologous tandem transplant for any condition other than germ cell tumors of the testes

9. Search of an international donor registry

10. An allogeneic tandem transplant

11. The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year

12. Experimental Treatment

13. Any other services or admissions related to any of the above-named exclusions

Specified Human Organ Transplants

Specified Human Organ Transplants require preapproval. If you do not get preapproval before you receive these services, it will not be covered and you will have to pay for it. However, once you get preapproval for the transplant, any services that you receive within one year from the date of the transplant will be covered as long as those services are Medically Necessary and related to the preapproved transplant.

When performed in a designated facility, the Plan pay for transplant of the following organs:

1. Combined small intestine-liver

2. Heart

3. Heart-lung(s)

4. Liver

5. Lobar lung

6. Lung(s)

7. Pancreas

8. Partial liver

9. Kidney-liver

10. Simultaneous pancreas-kidney

11. Small intestine (small bowel)

12. Multivisceral transplants (as determined by BCBSM)

The Plan also pays for the cost of getting, preserving and storing human skin, bone, blood, and bone marrow that will be used for Medically Necessary covered services.

All specified human organ transplant services must be provided during the Benefit Period if they are going to be paid by the Plan. It begins five days before the transplant and ends one year after the transplant. The only exceptions are anti-rejection drugs and other transplant-related prescription drugs.

When directly related to the transplant, the Plan pays for:

1. Facility and professional services

2. Anti-rejection drugs and other transplant-related prescription drugs, during and after the Benefit Period, as needed; the payment for these drugs will be based on BCBSM's Approved Amount.

3. During the first 24 months after the transplant, immunizations against certain common infectious diseases are covered. Immunizations that are recommended by the Advisory Committee on Immunization Practices (ACIP) are covered by BCBSM.

4. Medically Necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during the Benefit Period and is a direct result of the organ transplant surgery

Note: The Plan will pay for any service that you need to treat a condition that is a direct result of an organ transplant surgery. The condition must be a covered benefit.

The Plan also pays:

1. Up to $10,000 for eligible travel and lodging during the initial transplant surgery, including:

    - Cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a Child under the age of 18 or if the transplant involves a living-related donor)

Note: In some cases, the Plan may pay for return travel to the original transplant facility if you have an acute rejection episode. The episode must be emergent and must fall within the Benefit Period. The cost of the travel must still fall under the $10,000 maximum for travel and lodging.

    - Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient ("lodging" refers to a hotel or motel)

2. Cost of acquiring the organ (the organ recipient must be a Covered Individual.) This includes, but is not limited to:

    - Surgery to obtain the organ
    - Storage of the organ
    - Transportation of the organ
    - Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
    - Payment for covered services for a donor if the donor does not have transplant services under any health care Plan

Note: The Plan will pay the BCBSM Approved Amount for the cost of acquiring the organ.

Limitations and Exclusions

During the Benefit Period, the Deductible and Copayments do not apply to the specified human organ transplants and related procedures.

The Plan does not pay for the following for specified human organ transplants:

1. Services that are not BCBSM benefits

2. Services provided to a recipient who is not a Covered Individual

3. Living donor transplants not listed in this certificate

4. Anti-rejection drugs that do not have Federal Food and Drug Administration approval

5. Transplant surgery and related services performed in a nondesignated facility

Note: You have to pay for the transplant surgery and related services if you receive them in a nondesignated facility. If the surgery is Medically Necessary *and* approved by the BCBSM medical director, the Plan will pay for it.

6. Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and Hospitalization

7. Items that are not considered by BCBSM to be directly related to travel and lodging.

8. Routine storage cost of donor organs for the future purpose of transplantation

9. Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this certificate

10. Experimental transplant procedures. See page 100 for guidelines related to Experimental Treatment.

Urgent Care Services

The Plan pays for Physician services provided at an urgent care facility.

Value Based Programs

Provider-Delivered Care Management (PDCM)

PDCM services are covered only when they are performed in Michigan by BCBSM designated providers. Under PDCM, a care manager will coordinate your care.

Locations: The Plan pays for professional services for PDCM in the following locations, subject to the conditions described below:

1. An office

2. A participating outpatient Hospital or participating facility

3. A member's home

4. Other locations as designated by BCBSM

The Plan pays for PDCM services such as:

1. Telephone, individual face-to-face, and group interventions

2. Medication assessments to identify:

    - The appropriateness of the drug for your condition
    - The correct dosage
    - When to take the drug
    - Drug Interactions

3. Setting goals by your primary care Physician (PCP), your care manager, and yourself to help you manage your health better

Note: Covered services are subject to change.

Most PDCM services include support for setting goals and ensuring patient participation.

Eligibility

You are eligible to receive PDCM services if you have:

1. Agreed to actively participate with PDCM

2. A referral for care management services from your Physician

3. Your Physician will determine your eligibility and refer you for care management services based on factors, such as your:

    - Diagnosis
    - Admission status
    - Clinical status

Termination of Provider-Delivered Care Management

You may opt-out of PDCM at any time. The Plan may also terminate PDCM services based on:

1. Your nonparticipation in PDCM

2. Termination or cancellation of your BCBSM coverage

3. Other factors

The Plan does not pay for:

1. Services performed by providers who are not designated as PDCM providers

2. Services performed by providers outside the state of Michigan

Note: For more information on PDCM services, contact BCBSM Customer Service.

Total Care

Total Care services are covered only when they are performed by designated providers outside the state of Michigan and the member has an established relationship with the designated provider. Designated providers are identified by the local Blue Cross/Blue Shield Plan in the state where the Total Care services are performed.

Locations: The Plan pays for professional services for Total Care in the following locations, subject to the conditions described below:

1. An office

2. A participating outpatient Hospital or participating facility

3. A member's home

4. Other locations as designated by the local Blue Cross/Blue Shield Plan in the state where the services are provided

We pay for:

1. Services of out-of-state, providers who are designated by their local Blue Cross/Blue Shield Plan to provide care management services

2. Services such as:

    - Telephone, individual face-to-face, and group interventions
    - Medication assessments to identify:

- The appropriateness of the drug for your condition
- The correct dosage
- When to take the drug
- Drug Interactions

3. Setting goals by your primary care Physician (PCP), your care manager, and yourself to help you manage your health better

Note: Covered services are subject to change.

Most Total Care services include support for setting goals and ensuring patient participation. The Plan encourages in-person contact between you and your care managers.

Eligibility

Your Physician will determine your eligibility and refer you for care management services based on factors, such as your diagnosis, admission status, and clinical status

Termination of Total Care

You may opt-out of Total Care at any time. The local Blue Cross/Blue Shield Plan may also terminate Total Care services based on:

1. Your nonparticipation in Total Care
2. Termination or cancellation of your Plan coverage
3. Other factors

The Plan does not pay for:

1. Services performed by providers who are not designated by the local Blue Cross/Blue Shield Plan as Total Care providers
2. Services performed in Michigan

Note: For more information on Total Care services, contact BCBSM Customer Service.

How Providers are Paid

For information regarding how BCBSM pays for providers, facilities and supplies, the BlueCard PPO Program and Blue Cross Blue Shield Global Core Program see the Community Blue Group Benefits certificate excerpt attached titled How Providers Are Paid in Appendix A. Please note that some of the terms and cross references included in the excerpt will be inconsistent with the terms of the Plan. The terms of the Plan as described in this SPD shall govern in that instance. If you have any questions on how BCBSM will pay for providers, please contact the Plan Office or BCBSM.

Excluded Services

The services listed in this section are in addition to all other nonpayable services stated in the Plan.

The Plan does not pay for:

1. Noncontractual services that are described in your Case Management treatment Plan if the services have not been approved by BCBSM.
2. Gender reassignment services that are considered by BCBSM to be cosmetic, or treatment that is experimental or investigational.
3. Court ordered services

4. Hospital admissions for services that are not acute, such as:

    - Basal metabolism tests
    - Cobalt or ultrasound studies
    - Convalescence or rest care
    - Convenience items
    - Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
    - Diagnostic evaluations
    - Electrocardiography
    - Lab exams
    - Observation
    - Weight reduction
    - X-ray, exams or therapy
    - Those mainly for physical therapy, speech and language pathology services or occupational therapy

5. Hospital services that the Plan does not pay for:

    - Services that may be Medically Necessary but can be provided safely in an outpatient or office location
    - Custodial care or rest therapy
    - Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
    - Outpatient inhalation therapy
    - Sports medicine, patient education or home exercise programs

6. Facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonHospital institution

Note: If a nursing home is your primary residence, then the Plan will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

7. Professional provider services that the Plan does not pay for:

    - Services, care, supplies or devices not prescribed by a Physician
    - Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or Children
    - Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed on page 89.
    - Weight loss programs (unless covered elsewhere in or otherwise required by law)
    - Services provided during nonemergency medical transport
    - Experimental Treatment
    - Prescription drug compounding kits or services provided to you related to the kits
    - Hearing aids or services to examine, prepare, fit or obtain hearing aids
    - Services provided by persons who are not eligible for payment or not appropriately credentialed or privileged. Providers who are not legally authorized or licensed to order or provide such services.

Note: If a participating BCBSM PPO in-network provider has not been credentialed or privileged by BCBSM to perform a service, they will be financially responsible for the entire cost of the service. They cannot bill you for their services. They also cannot bill you for any Deductibles, Copayments, or Coinsurance amounts.

If you decide to get medical services from a nonparticipating out-of-network provider, who is not credentialed or privileged to perform those services, you will have to pay for the entire cost of the service.

- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
- Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
- Infertility services that do not treat a medical condition other than infertility. This can include services such as:
    - Sperm washing
    - Post-coital test
    - Monitoring of ovarian response to ovulatory stimulants
    - In vitro fertilization
    - Ovarian wedge resection or ovarian drilling
    - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
    - Diagnostic studies done for the sole purpose of infertility assessment
    - Any procedure done to enhance reproductive capacity or fertility

Note: You or your Physician can call the Plan Office to determine if other proposed services are a covered benefit.

- Sports medicine, patient education (except as otherwise specified) or home exercise programs
- Screening services (except as otherwise stated)
- Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

Note: If a nursing home is your primary residence, then the Plan will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

- Non-contractual services described in your Case Management treatment Plan when such services have not been approved by BCBSM.

8. Any services related to an injury or condition which is a direct or indirect result of an automobile accident. The following rules apply to this exclusion.
    - This exclusion applies to Employees, Retirees and Dependents covered under the Employee Medical Plan or E&D Retiree Plan and who are Michigan residents.
    - This exclusion applies whether or not you have no-fault automobile insurance.
    - This exclusion does not apply to services for an injury or condition resulting from a motorcycle accident, unless the services are payable under no-fault auto insurance coverage. For additional information, see the Claims and Appeals Procedures section of this booklet beginning on page 126.
    - For non-Michigan residents, the Plan will pay for services to treat an injury or condition that is a direct or indirect result of an automobile accident only on a secondary basis and only when benefits do not duplicate those available under your no-fault automobile insurance policy. For additional information, see the Claims and Appeals Procedures section of this booklet beginning on page 126.

General Plan Conditions

This section explains the conditions that apply to medical benefits. They may make a difference in how, where and when benefits are available to you.

Coverage for Drugs and Devices

The Plan does not pay for a drug or device prescribed for uses or in dosages other than those approved by the Food and Drug Administration. (This is called the off-label use of a drug or device.) However, the Plan will pay for them and the reasonable cost of supplies needed to administer them, if the prescriber proves that the drug or device is recognized for treatment of the condition it is prescribed for by:

1. The American Hospital Formulary Service Drug Information
2. The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
3. Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

Note: Chemotherapeutic drugs are not subject to this general condition

If a prescription is for a contraceptive drug or device, the prescriber must show why all other contraceptives covered under the member's benefits cannot be used by the member.

Experimental Treatment

The Plan does not pay for:

1. Experimental Treatment. This includes experimental drugs and devices
2. Services, drugs, devices, and administrative costs related to Experimental Treatment
3. Costs of research management.

Note: See page 53 for "Clinical Trials (Routine Patient Costs), "Oncology Clinical Trials" and "Services That Are Payable" below for exceptions.

A service may be considered experimental if:

1. Medical literature or clinical experience cannot say whether it is safe or effective for treatment of any condition, or
2. It is shown to be safe and effective treatment for some conditions. However, there is inadequate medical literature or clinical experience to support its use in treating the patient's condition, or
3. Medical literature or clinical experience shows the treatment to be unsafe or ineffective for treatment of any condition, or
4. There is a written experimental or investigational Plan by the attending provider or another provider studying the same treatment, or
5. It is being studied in an on-going Clinical Trial, or
6. The treating provider uses a written informed consent that refers to the treatment, as:
   - Experimental or investigational or
   - Other than conventional or standard treatment.

Note: Other factors may be considered.

When available, these sources are considered in deciding if a treatment is experimental under the above criteria:

1. Scientific data (*e.g.*, controlled studies in peer-reviewed journals or medical literature)

2. Information from the Blue Cross and Blue Shield Association or other local or national bodies

3. Information from independent, nongovernmental, technology assessment and medical review organizations

4. Information from local and national medical societies, other appropriate societies, organizations, committees or governmental bodies

5. Approval, when applicable, by the FDA, the Office of Health Technology Assessment (OHTA) and other government agencies

6. Accepted national standards of practice in the medical profession

7. Approval by the Hospital's or medical center's Institutional Review Board

Note: Other sources may be considered.

Services That Are Payable

The Plan does pay for Experimental Treatment and its related services when **all** of the following are met:

1. The Experimental Treatment is considered to be conventional treatment when used to treat another condition (*i.e.*, a condition other than what you are currently being treated for).

2. It is covered under your certificate when provided as conventional treatment.

3. The services related to the Experimental Treatment are covered under your certificate when they are related to conventional treatment.

4. The Experimental Treatment and related services are provided during a BCBSM-approved oncology Clinical Trial (check with your provider to determine whether a Clinical Trial is approved by BCBSM), or the related services are Routine Patient Costs that are covered under "Clinical Trials (Routine Patient Costs)".

Limitations and Exclusions

1. This general condition does not add coverage for services not otherwise covered under the Plan

2. Drugs or devices given to you during a BCBSM-approved oncology Clinical Trial will be covered only if they have been approved by the FDA. The approval does not need to be for treatment of the member's condition. However, the Plan will not pay for them if they are normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

Fraud, Waste, and Abuse

The following are not covered by the Plan:

1. Services that are not Medically Necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;

2. Services that are performed by a provider who is sanctioned at the time the service is performed.

Note: Sanctioned providers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

You will be notified if any provider you have received services from during the previous 12 months has been sanctioned. You will have 30 days from the date you are notified to submit claims for services you received prior to the provider being sanctioned. After those 30 days has passed, the Plan will not process claims from that provider.

Genetic Testing

The Plan will not:

1. Request or require genetic testing of any person eligible for or covered under the Plan

2. Limit coverage based on genetic information related to you, your spouse, or your Dependents

Pharmacy Fraud, Waste, and Abuse

The Plan does not pay for the following:

1. Prescription drugs that are not Medically Necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;

2. Drugs prescribed by a prescriber who is sanctioned at the time the prescription is dispensed.

Note: Sanctioned prescribers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

You will be notified if any prescriber you have received services from during the previous 12 months has been sanctioned. You will be given 30 days' notice, after which the Plan will not pay for drugs prescribed by the sanctioned prescriber.

Semiprivate Room Availability

If a semiprivate room is not available when you are admitted to a participating Hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you must pay for any additional cost. The Plan will not pay the difference between the cost of Hospital rooms covered by your certificate and more expensive rooms.

Services That Are Not Payable

The Plan does not pay for services that:

1. You legally do not have to pay for or for which you would not have been charged if you did not have coverage under this certificate

2. Are available in a Hospital maintained by the state or federal government, unless payment is required by law

3. Can be paid by government-sponsored health care programs, such as Medicare, for which a member is eligible. The Plan does not pay for these services even if you have not signed up to receive the benefits from these programs. However, the Plan will pay for services if federal laws require the government-sponsored program to be secondary to this coverage.

4. Are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results

5. Are not listed in this SPD as being payable

Unlicensed and Unauthorized Providers

The Plan does not pay for services provided by persons who are not:

1. Appropriately credentialed or privileged (as determined by BCBSM), or

2. Legally authorized or licensed to order or provide such services.

Workers' Compensation

The Plan does not pay for treatment of work-related injuries covered by workers' compensation laws or work-related services you get at an Employer's medical clinic or other facility.

Prescription Drug Coverage

Your prescription drug coverage is provided under the Preferred RX Program. BCBSM administers the Preferred RX Program.

Your cost-sharing and annual out-of-pocket maximum for prescription drugs is described in the BAAG. The Plan will pay for each covered drug, each refill of a covered drug, and select over-the-counter (OTC) drugs prescribed by a Physician, as described in this section.

Mandatory Prior Authorization

Some drugs require prior authorization from BCBSM before the Plan will pay for them. If prior authorization is not requested or received from us, the Plan will not pay for the drug. You will be responsible for 100 percent of the pharmacy's charge. It is important to make sure your provider gets the prior authorization before you receive these drugs. You or your provider should contact BCBSM to determine whether a drug must be preauthorized.

Covered Drugs Obtained from an In-Network Pharmacy

The Plan will pay an In-Network Pharmacy for your covered prescription drugs minus your cost-sharing. This includes a covered drug that contains bulk chemical powders approved by BCBSM.

The Plan will pay prescription drug benefits for a 90-day supply of medication. For quantities of 84 through 90 days, you are subject to only one Copayment and it is **doubled** from what it would be for a 34 day supply.

All **retail** 90-day supplies of medication must be obtained from a "90-Day Retail Network" provider subject to the following limitations:

1. Prescriptions for quantities of 35 through 83 days will NOT be covered.

2. Prescriptions for quantities of 84 through 90 days will be covered.

Note: Members may continue to obtain a 34-day supply of medication from a "90-Day Retail Network" provider.

For Maximum Allowable Cost (MAC) Drugs

If you have a prescription filled by an In-Network Pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the Copayment and/or Deductible, if applicable.

If you obtain a brand name drug when a generic equivalent drug is available, you must pay:

1. the difference between the Maximum Allowable Cost and the BCBSM Approved Amount for the brand name drug PLUS

2. your Copayment and/or Deductible, if applicable.

Exception: If your Physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your Copayment and/or Deductible, if applicable.

These rules also apply if you obtain drugs by mail order when you have the BCBSM Mail Order Prescription Drug Program.

Drugs obtained from participating/In-Network Mail-Order Providers

The Plan covers drugs obtained from participating/In-Network Mail-Order Providers.

You must pay a separate Copayment for mail-order drugs that are supplied to cover up to 30 days and supplied to cover between 31 and 90 days. Your Copayment for 30-day supplies and 31-90-day supplies are described in the BAAG.

Note: If the Approved Amount is less than the minimum Copayment, you pay only the Approved Amount for the drug.

Select Specialty Drugs

The Plan reserves the right to limit the quantity of select* specialty drugs to no more than a 15-day supply for each fill.

> **Note:** Applicable cost share applies. Any applicable prescription drug Copayments required in your certificate and/or riders will be reduced by one-half (1/2) for each specialty medication limited to a 15-day fill.

Select Controlled Substances

The Plan reserves the right to limit the quantity and day supply of select* controlled substances.

Note: The initial fill is limited to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply.

Select controlled substances include, but are not limited to:

1. Hydromorphone
2. Oxycodone
3. Tapentadol

The initial fill limitation for select controlled substances will not apply to members with a cancer diagnosis or who are terminally ill.

*Select specialty drugs and select controlled substances are subject to change. Please see BCBSM's list of drugs that may have these limits at bcbsm.com/pharmacy.

Covered Drugs Obtained from an Out-of-Network Pharmacy

If you receive covered drugs from a nonparticipating pharmacy, you may have to pay additional cost-sharing. Additionally, you must pay the pharmacist the full cost of the drug and submit a claim form and proof of payment, including the National Drug Code (NDC) of the drug dispensed. To obtain a claim form, please refer to the "How to Reach Us" section at the back of this booklet for the phone number or address of the Customer Service center nearest you or visit http://www.bcbsm.com/.

Medication Synchronization

If you take more than one maintenance prescription drug, you can arrange to have your prescriptions filled at the same time.

To order to qualify for this service, you must meet the following criteria:

1. You, your prescriber and a pharmacist agree that synchronizing your medications for treatment of your chronic long-term care condition is in your best interest

2. The prescription drugs that will be synchronized meet the following requirements:

    - Are covered under your certificate
    - Are used for the management and treatment of chronic long-term care conditions and have authorized refills available
    - If prior authorization is required, that authorization has been obtained
    - Can be split over a short fill period so that they can be synchronized

If you qualify for this service, the Plan will allow for a supply from 1 to 29 days to be dispensed in order to synchronize your maintenance drugs.

Exclusions

1. Mail order drugs
2. Select products that are subject to special fill limits
3. Prescription drugs that:

    - Do not meet prior authorization requirements
    - Cannot be split into short fill periods
    - Do not meet quantity limits or dose optimization criteria

4. Schedule 2-5 controlled substances except anti-epileptic drugs can be synchronized

Note: You must pay your participating provider cost-sharing for these drugs. You are also responsible for any prorated daily cost-sharing that would apply in order to synchronize your medications. Because your medication costs may vary, please see the specific Copayment chart that explains your cost-sharing amount for each drug.

Contraceptive Medication

The Plan covers FDA-approved generic and select brand-name contraceptive drugs.

When a covered generic or select brand-name contraceptive drug is dispensed by an In-Network Pharmacy, the Plan will pay 100% of the Approved Amount. You have no out-of-pocket cost in these instances.

If you get an FDA-approved brand-name contraceptive drug that is not on the BCBSM list, you pay applicable cost-sharing.

Note: You do not have to pay cost-sharing for brand-name contraceptive drugs not on the list if your prescriber receives prior authorization from BCBSM.

When a covered generic or select brand-name contraceptive drug is dispensed by a nonparticipating pharmacy, you are responsible for:

1. The member cost-sharing amounts for generic and brand-name drugs as described in this certificate and/or related riders;
2. 25% of the Approved Amount (if the drug is obtained in the United States); and
3. Any amount in excess of the Approved Amount.

Chemotherapy Specialty Pharmaceuticals

There are certain chemotherapy specialty drugs that must be preauthorized. The Plan only pay for these drugs when you get them from an approved In-Network Pharmacy.

This prior authorization rule applies to all chemotherapy specialty drug claims. Your prescriber must contact BCBSM and to get prior authorization for these chemotherapy specialty drugs. If preauthorization is requested, but is not approved by BCBSM, you have a right to appeal under applicable law. If the appeal fails, you will be responsible for 100 percent of the pharmacy's charge.

If preauthorization is not received, the Plan will not pay for the drug. You will be responsible for 100 percent of the pharmacy's charge.

Preventive Drugs, Immunization Vaccines, Supplements and Vitamins

The Plan pays for the following as required by the ACA:

1. Preventive drugs
2. Select immunization vaccines
3. Supplements
4. Vitamins

The Plan reserves the right to only pay for over-the-counter versions of any drugs, supplements and vitamins required to be covered under the ACA.

A prescription is required for most preventive drugs, immunization vaccines, supplements and vitamins to be covered. They must be:

1. Dispensed by a participating/In-Network Pharmacy and
2. Approved by the FDA, when FDA approval is available and
3. Meet coverage criteria required under the ACA.

Note: Some services may not need a prescription. An example would be immunization vaccines you might receive in a pharmacy.

You pay no cost-sharing for covered generic or select brand-name drugs if they are preventive drugs, supplements or vitamins, and you get them from a participating or In-Network Pharmacy

The Plan will pay 100 percent of the Approved Amount when a participating or In-Network Pharmacy fills a prescription for other drugs. However, your prescriber must receive prior authorization from BCBSM.

To see a complete list of the services and immunizations that must be covered under the ACA, visit https://www.healthcare.gov/coverage/preventive-care-benefits/. You may also contact the Plan Office or BCBSM Customer Service.

When a covered generic preventive drug, supplement or vitamin is dispensed by an Out-of-Network Pharmacy, you are responsible for:

1. The member cost-sharing amounts for generics, as described in this certificate and/or related riders;
2. 25% of the Approved Amount (if the drug is obtained in the United States); and
3. Any amount in excess of the Approved Amount.

Clinical Trials (Routine Patient Costs)

The Plan covers all items and services related to an Approved Clinical Trial if they are covered under the Plan. In other words, everything a member would get who is not in a Clinical Trial is also available as part of an Approved Clinical Trial.

The Plan does not pay for:

1. The experimental or investigational item, device or service itself

2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Note: BCBSM may require you to go to a BCBSM-contracted provider who is already part of an Approved Clinical Trial. The provider may be participating or in-network. An exception would be if the trial is conducted outside of Michigan.

Gender Dysphoria Treatment

The Plan covers any prescribed drugs that are Medically Necessary for the treatment of gender dysphoria.

The Plan does not pay for:

1. Prescription drugs considered to be cosmetic.

2. Prescription drugs that are experimental or investigational.

For All Covered Drugs

If your prescriber prescribes certain brand-name drugs but then changes your prescription to a generic drug your Copayment or Coinsurance may initially be waived for a period of time. After this initial period of time, you must pay the generic Copayment or Coinsurance if a generic drug continues to be prescribed.

Pharmacy Savings Program

The Plan utilizes a pharmacy savings program to save money on the cost of prescription drugs for you and the Plan. Health Plan Advocate (HPA) has been retained to assist you and your Dependents in obtaining and enrolling in any available Prescription Drug Assistance Programs that may be available for drugs you have been prescribed that cost $400 or more per fill. You can contact HPA for assistance by calling 616-575-0211 ext. 206.

For any prescription that costs $400 or more for which a Prescription Drug Assistance Program is available, one of the following charges will apply for the duration of the prescription for the entire Calendar Year:

1. No charge if you apply for and use an available Prescription Drug Assistance Program. If there is a required point-of-sale Copayment, you must pay the Copayment and the Plan will reimburse you.

2. A 50% Copayment if you do not use the available Prescription Drug Assistance Program. The 50% Copayment will continue to apply until any amounts available under the Prescription Drug Assistance Program are exhausted or your annual out-of-pocket maximum has been satisfied; or

Any amounts paid by a Prescription Drug Assistance Program will not accrue towards your annual out-of-pocket maximum.

If a Prescription Drug Assistance Program is not available or the prescription costs less than $400, the Plan's standard prescription drug Copayments will apply. See the BAAG for the standard prescription drug Copayment amounts.

Prescription Drugs Not Covered

The Plan will not cover:

1. Contraceptive medications and devices that are not required to be covered under the ACA

2. Hemophilia medications and the supplies for the infusion

3. Any drugs prescribed for cosmetic purposes

4. The charge for any prescription refill in excess of the number specified by the prescriber or any refill dispensed one year after the prescriber's prescription order was written

5. Administration of covered drugs except for select immunization vaccines

6. Non-self-administered injectable drugs (except for select immunization vaccines)

7. Any vaccine given solely to resist infectious diseases (except for select immunization vaccines)

8. Therapeutic devices or appliances, including, but not limited to hypodermic or disposable needles and syringes when not dispensed with the following:

    - A covered injectable drug
    - Insulin
    - Self-administered chemotherapeutic drugs.

9. Non-self-administered contraceptive drugs or devices

10. Drugs obtained from nonparticipating/Out-of-Network Mail-Order providers, including Internet Providers.

11. More than a 30-day supply of a covered prescription drug that BCBSM defines as a “specialty pharmaceutical” whether or not the drug is obtained from a 90-Day Retail Network provider. The Plan may make exceptions if a member requires more than a 30-day supply.

12. More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescriber obtains prior authorization from BCBSM. A list of drugs that may have quantity and/or dose limits is available at the BCBSM website at http://www.bcbsm.com/.

13. Diagnostic agents

14. Any drug the Plan determines to be experimental or investigational.

15. Any covered drug entirely consumed at the time and place of the prescription

16. Anything other than covered drugs and services

17. Any drug or device prescribed for uses or in dosages other than those specifically approved by the Food and Drug Administration. This is often referred to as the off-label use of a drug or device. (However, the Plan will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescriber can substantiate that the drug is recognized for treatment of the condition for which it was prescribed.) Some chemotherapeutic drugs may be subject to prior authorization review.

18. Select chemotherapy specialty pharmaceuticals that are not preauthorized

19. Drugs that are not labeled "FDA approved," except for state-controlled drugs and insulin, or such drugs that BCBSM designates as covered

20. Drugs newly approved by the FDA and not yet reviewed for coverage determination by BCBSM

21. Drugs not recommended by BCBSM

Note: If a decision is made to approve a non-covered drug, you will be required to pay the non-preferred Copayment.

22. Drugs that are covered under the Plan's medical benefit

23. Drugs obtained before a person is a Covered Individual

24. Claims for covered drugs submitted after the applicable time limit for filing claims

25. Support garments or other nonmedical items

26. Compounded drugs that contain any bulk chemical powders that are not approved by BCBSM

27. Elective Abortions: Services, devices, drugs or other substances provided by a pharmacy that are prescribed to terminate a woman's pregnancy for a purpose other than to: increase the probability of a live birth; preserve the life or health of the Child after a live birth; or remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Any service, device, drug or other substance related to an elective abortion is also excluded.

Note: Elective abortions do not include:

- A prescription drug or device intended as a contraceptive;
- Services, devices, drugs or other substances provided by a Physician to terminate a woman's pregnancy because her physical condition, in the Physician's reasonable medical judgment, requires that her pregnancy be terminated to avert her death; and
- Treatment of a woman experiencing a miscarriage or who has been diagnosed with an ectopic pregnancy.

28. Prescription drug services for the treatment of gender dysphoria that are considered by BCBSM to be cosmetic, or prescription drug treatment that is experimental or investigational.

29. Compounded hormones

30. Refills of prescriptions for covered drugs that exceed BCBSM's limits:

    - BCBSM does not cover refills that are dispensed before 75 percent of the time the prescription covers has elapsed.
    - BCBSM does not cover more refills than your prescription allows.

31. Impotence Drugs

32. Weight Loss Drugs

Death Benefits

Only active Eligible Employees are eligible for Death Benefits. Retirees or an Employee continuing coverage as a COBRA Qualified Beneficiary are not eligible for this benefit.

Amount of Benefit

A Death Benefit in the amount of $15,000 is payable by the Plan (regardless of the cause of death) upon the death of an active Eligible Employee or Employee making regular self-payments, provided that written notice of the death is sent to the Plan Office within 12 months of such Employee's date of death. Payment of the Death Benefit will be subject to applicable tax reporting and withholding. No Death Benefit is payable on behalf of a person covered by the Plan as a Retiree or an Employee continuing coverage as a COBRA Qualified Beneficiary.

Designation of Beneficiary

The Employee may designate a beneficiary or may change a previously designated beneficiary by filing with the Plan a properly completed beneficiary form, one that is signed, dated and witnessed. The designation or change, when received by the Plan, shall take effect as of the date the beneficiary form is received by the Plan, whether or not the Employee is living at the time of the notice is received. However, any payment made by the Plan prior to receipt of such designation or change shall fully discharge the Plan to the extent of such payment.

The right to change beneficiaries is reserved to the Employee and the consent of the beneficiary or beneficiaries shall not be required to change a beneficiary.

If a married Employee designates his or her spouse as beneficiary and that marriage is legally terminated (*e.g.*, by divorce, legal separation or decree of separate maintenance), then any prior beneficiary designation naming the former spouse as beneficiary shall be null and void. If the Employee desires to again designate the former spouse as beneficiary, the Employee must complete and submit a new beneficiary designation form after the marriage is legally terminated, designating such former spouse as beneficiary or a qualified domestic relations order must be on file with the Plan prior to payment designating the former spouse as beneficiary.

Payment of Benefits

The Plan retains the right to defer payment of any death benefit until a copy of the Employee's certificate of death is received by the Plan.

The Death Benefit will be payable to the Employee's eligible designated beneficiary. If at the time of death, there is no eligible designated beneficiary with respect to all or any part of the benefits, no eligible designated beneficiary survives the Employee or if no properly completed beneficiary designation form is received by the Plan, the Death Benefit will be paid to the surviving person or persons in the first of the following classes of survivors with living members:

1. Spouse;

2. Child or Children, including legally adopted Children

3. Parents

4. Brothers and sisters; or

5. Executor or administrator of the Employee's estate or, if there is no estate, to the Employee's legal representative responsible for distributing the Employee's assets to beneficiaries.

In determining such person or persons the Plan may rely upon an affidavit by a member of any of the classes of preference beneficiaries. If two or more persons become entitled to benefits as members of a class of preference beneficiaries, they shall share equally.

Any Death Benefits payable to a minor or incompetent may be paid to the legally appointed guardian of the minor or the incompetent. If no such guardian exists, benefits may be paid to such adult or adults as have, in the Trustees' opinion, assumed the custody and principal support of such minor or incompetent. In any event, the Death Benefit will be paid consistent with Michigan's Uniform Transfer to Minors Act.

Payment to the beneficiary will be made in a lump sum. No installment payments are permitted.

Payment to one described above will release the Plan from all further liability to the extent of the payments made.

Accidental Death and Dismemberment Benefit

If an Employee eligible for Accidental Death and Dismemberment ("AD&D") Benefits under the Plan sustains accidental bodily injury due to an unexpected and external source and, as a result of that injury, suffers, directly and independently of all other causes and within 90 days of the injury, one of the specific losses described below, the Plan will pay the amount of benefits provided below for the type of loss suffered, subject to the limitations described below. No AD&D Benefit is payable on behalf of a person covered by the Plan as a Retiree or an Employee continuing coverage as a COBRA Qualified Beneficiary.

Maximum Payment

In no event, shall the total amount payable for all losses suffered by an Employee as a result of any one accident exceed the "Full Amount" set forth below. No loss sustained before the accident will be included in determining the amount payable. Payment will be made in a lump sum.

Accidental Death Benefits

For loss of life, the Full Amount is payable in accordance with the beneficiary provisions of the Employee's Death Benefit.

Accidental Dismemberment Benefits

Benefits for accidental dismemberment are payable to the Employee as follows:

Type of Loss	Amount Payable
Both hands or both feet	Full amount--Paid to Employee
Sight of both eyes	Full amount--Paid to Employee
One foot and sight of one eye	Full amount--Paid to Employee
One hand and sight of one eye	Full amount--Paid to Employee
One hand and one foot	Full amount--Paid to Employee
One hand or one foot or sight of one eye	One-half of the Full amount--Paid to Employee

Loss of sight means total and irrecoverable loss of sight. Loss of a hand means severance of the hand at or above the wrist. Loss of a foot means severance of the foot at or above the ankle.

Amount of Benefit

The Full Amount of the benefit is $10,000 and one half of the Full Amount of the benefit is $5,000.

Limitations

In addition to other limitations and requirements described above, no AD&D Benefit will be payable for a loss:

1. Which occurs more than 90 days after the date of the accident or which results from an accident that occurred while the Employee was not eligible for this benefit; or

2. Which is caused, or contributed to. by or results directly or indirectly from any of the following:

    - Intentionally self-inflicted injury or suicide or attempted suicide;
    - Bodily or mental infirmity, disease or infections (except pyogenic infections or septic infections of a visible wound accidentally sustained);
    - War or an act of war or service in any military force of any country, whether declared or undeclared;
    - To which a contributing cause is the use of any drug, narcotic or hallucinogen not prescribed by a Physician or not used in the manner prescribed by the Physician, provided that the presence of alcohol, exclusively, will not be deemed use of a drug for purpose of this exclusion;
    - Medical or surgical treatment;
    - Due to riding as a passenger in an aircraft other than as a fare paying customer in a commercial aircraft;
    - Commission of, or attempt to commit, a felony or being engaged in an illegal occupation;
    - Occupational injury or sickness.

Discount Vision Program

Vision services are available through a discount program through Vision Service Plan ("VSP") called the VSP Vision Savings Pass. The discounts are only available from a VSP Network Provider. To find a VSP Provider, call **1-800-877-7195** or log on to the VSP Website at www.vsp.com.

Discount Program –

Covered Employees and Dependents can receive the following discounts from a VSP Network Provider for eye care. Eyewear (*e.g.*, lenses and frames) discounts are given when the VSP Provider has performed an eye exam within the prior 12 months.

Eye Exam	**VSP Network Provider – Discount Provided**
Complete eye exam by an ophthalmologist or optometrist (Well Vision Exam)	20% discount off a thorough eye exam or $50 if complete pair of prescription glasses are purchased (one exam per Calendar Year)

Lenses and Frames	**VSP Network Provider**
Retinal Screening	Guaranteed pricing with “Well Vision Exam” (not to exceed $39)
Lenses – with purchase of a complete pair of prescription glasses	Single Vision - $40.00 Lined Bi-Focal - $60.00 Lined Tri-Focal - $75.00 Polycarbonate for Children - $0
Lens enhancements	20% - 25% discount for progressive, scratch-resistant and anti-reflective coatings
Frames – with purchase of a complete pair of prescription glasses	25% discount
Sunglasses	20% discount on non-prescription sunglasses
Contact lens exam (fitting and evaluation)	15% discount from regular price

Laser Vision Care Program	**VSP Network Provider**
Laser surgery including PRK, LASIK, and Custom Lasik **Note:** Custom Lasik coverage is only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to you. Laser Vision Care Discounts are only available from a VSP-contracted facilities.	Discounts average 15% off or 5% off if the laser center is offering a promotional price

Vision Benefits Not Covered

Additional charges for:

- Lenses tinted darker than Rose tint #2 (such as sunglasses)
- Oversize lenses (61mm and larger)
- Blended lenses
- Photochromic lenses
- Progressive/multifocal lenses
- Coating/laminating of a lens or lenses
- Cosmetic lenses/processes
- Two pairs of glasses instead of bifocals
- Antireflective lenses

Dental Care & Vision Coverage

Eligible Active Employees and Eligible Retirees Who Have Elected To Purchase Dental Coverage

The Plan provides a program of dental benefits to the Eligible Employees of a participating Local Union that elects to provide the benefit within its jurisdiction to Eligible Employees. The Plan also provides a program of dental benefits to Eligible Retirees receiving Retiree benefits from the Plan who timely elect the dental benefit program on a monthly self-payment basis. Currently, the participating locals are Locals 445, 692, 948 and 498. The Plan also provides participating Employers who participate on behalf of their Non-Bargaining Unit Employees the right to elect dental coverage. Benefits are available to the participating Eligible Employee and the Employee's Eligible Dependents.

The Plan offers multiple types of dental coverage that may be selected pursuant to rules adopted by the Trustees. Further, the Plan offers an optional vision benefit through an arrangement involving Delta Dental and VSP. Currently, Local 498 and 948 has elected the vision option.

Network Access Information

Dental Care Coverage is available through one of two dental provider networks offered through Delta Dental: Delta PPO and Delta Premier. Although Eligible Employees may use any dentist, you will likely save money if you use a dentist that participates in either the Delta PPO network or the Delta Premier network.

Delta Dental PPO Dentist - is a licensed dentist who has signed an agreement with Delta Dental to accept payment based on a reduced fee schedule. Delta Dental's payment and the patient's payment, if any, are accepted by the Delta Dental PPO Dentist as payment in full. Delta Dental's payment is sent directly to the Delta Dental PPO Dentist.

Delta Dental Premier Dentist - is a licensed dentist who has signed a contract with Delta Dental agreeing to accept direct payment from Delta Dental. He/she also has agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA). MPA means the total dollar amount allowed under the contract for a specific benefit. You will be responsible for coinsurance amounts and costs for non-covered services. You will receive an Explanation of Benefits form indicating the amount Delta Dental has paid to the Delta Dental Premier Dentist and the amount, if any, you owe.

Noncontracted Dentist - If your dentist has not signed a contract with Delta Dental, payment will be calculated based on the MPA but will be sent directly to you. You are responsible for reimbursing your dentist through his/her usual billing procedure. If the fee charged is not allowed in full, Delta Dental is not implying that the dentist is overcharging. Dental fees vary and are based on the dentist's overhead, skill, and experience. Therefore, not every dentist will have fees that fall within the MPA fee range.

You can find a participating dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more at your convenience using the Delta Dental Consumer Toolkit at deltadentalmi.com. You can also contact Delta Dental Customer Service at 800-524-0149 to find participating providers in your area.

Dental Program Option 1

Plan Covered Services	**Amount Plan Pays**		
	Delta Dental PPO™ Dentist	**Delta Dental Premier® Dentist**	**Nonparticipating Dentist***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%

Plan Covered Services	Amount Plan Pays		
	Delta Dental PPO™ Dentist	**Delta Dental Premier® Dentist**	**Nonparticipating Dentist***
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	100%	100%

*When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mount X-rays (which include bitewing X-rays) or a panorex are payable once in a any five-year period.
- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 19 and under. The surface must be free from decay and restorations.
- Periodontal maintenance is a Covered Service.
- Full and complete dentures, and services related to dentures are not Covered Services.
- Implants and implant related services are not Covered Services.
- Crowns over implants and their related services are not Covered Services.
- Occlusal guards are not Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world. You can now receive expert dental care when you are outside of the United States through our Passport Dental Program. This program give you access to worldwide network of dentist and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental Information Sheet.

Maximum Payment – None.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered as defined by the Plan.

Eligible People – As defined by the Plan.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26. Including your Children who are married, who no longer live with you, who are not your Dependents for Federal Income Tax purposes, and/or who are not permanently disabled.

Enrollees and their Dependents choosing either dental plan are required to remain enrolled for a period of 12 months. Should an enrollee or Dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in this Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's application as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which employment is terminated.

Dental Program Option 2

Plan Covered Services	**Amount Plan Pays**		
	Delta Dental PPO™ Dentist	**Delta Dental Premier® Dentist**	**Nonparticipating Dentist***
Diagnostic & Preventive (Class I)			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Service (Class II)			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to prosthetic appliances	50%	50%	50%
Major Services (Class III)			
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%

*When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mount X-rays (which include bitewing X-rays) or a panorex are payable once in a any five-year period.
- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 19 and under. The surface must be free from decay and restorations.
- Veneers are payable on incisors, cuspids and bicuspids once per tooth in any five-year period for people age 12 and older when necessary due to fracture or decay.
- Composite resin (white) restorations are payable on posterior teeth.

- Metallic inlays are Covered Services.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world. You can now receive expert dental care when you are outside of the United States through our Passport Dental Program. This program give you access to worldwide network of dentist and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental Information Sheet.

Maximum Payment – $1,200 per person total per Benefit Year on all services, except diagnostic and preventive services, emergency palliative treatment, X-rays, brush biopsy, and sealants (Class I Benefits).

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered as defined by the Plan.

Eligible People – As defined by the Plan.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26. Including your Children who are married, who no longer live with you, who are not your Dependents for Federal Income Tax purposes, and/or who are not permanently disabled.

Enrollees and their Dependents choosing either dental plan are required to remain enrolled for a period of 12 months. Should an enrollee or Dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in this Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's application as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which employment is terminated.

Dental Program Option 3

Plan Covered Services	**Amount Plan Pays**		
	Delta Dental PPO™ Dentist	**Delta Dental Premier® Dentist**	**Nonparticipating Dentist***
Diagnostic & Preventive (Class I)			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Service			

Plan Covered Services	Amount Plan Pays		
	Delta Dental PPO™ Dentist	**Delta Dental Premier® Dentist**	**Nonparticipating Dentist***
Minor Restorative Services – fillings and crown repair	80%	80%	60%
Endodontic Services – root canals	80%	80%	60%
Periodontic Services – to treat gum disease	80%	80%	60%
Oral Surgery Services – extractions and dental surgery	80%	80%	60%
Other Basic Services – misc. services	80%	80%	60%
Relines and Repairs – to prosthetic appliances	80%	80%	60%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
TMD Treatment – treatment of the disorder of the temporomandibular joint	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Service			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit	Up to Age 19		

*When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

Maximum Payment - $1,200 per person total per calendar year on diagnostic & preventive, basic services, and major services. $1,500 per person total per lifetime on orthodontics.

Deductible - $50 deductible per person total per calendar year limited to a maximum deductible of $150 per family per calendar year on all services except diagnostic and preventive services, emergency palliative treatment, sealants, brush biopsy, and orthodontic services.

Optional Vision Benefit

Exam/lens/frame/contacts (instead of glasses) every 12 months
$10 exam copay
$10 Materials copay
Up to $60 contact lens fit evaluation copay
$150 frames/contacts allowance
Standard progressive lenses covered
Lens Enhancements $17
Scratch-resistant coating $75 light=reactive single lenses

Special Fund

The Special Fund is a health reimbursement arrangement, which is a benefit program that can have financial and flexibility advantages. The Special Fund can save you money by allowing you to cover a wide range of expenses with untaxed income rather than after-tax income. It is not, however, a savings account from which you can withdraw at will. You are not vested in the balance. Payments can be made only for the expenses shown below.

Eligibility

You are eligible to participate in the Special Fund if a Collective Bargaining Agreement or other agreement requires an Employer to contribute to the Special Fund on your behalf, provided you also meet the Plan's initial eligibility rules. You can continue to access your Special Fund after your Plan coverage ends.

Funding Your Special Fund Account

For every hour that you work, Employers in this jurisdiction will make a contribution into an account in your name ("Account" or "Special Fund Account"). The amount of the contribution is determined by the Collective Bargaining Agreement under which you are working or other agreement pursuant to which contributions are made on your behalf and may change from time to time.

Work that you perform for Employers in other jurisdictions may also generate contributions to your Account, subject to reciprocity rules.

This program has been designed so that the contributions to your Account, the interest that could be credited to your Account, and the reimbursements paid from it will not be considered taxable income to you. You should understand that tax laws and regulations, as well as interpretations, change from time to time and you should contact your tax advisor concerning the taxation of Special Fund reimbursements.

Nontaxable interest may be credited to your Account annually, at the discretion of the Board of Trustees.

Your Account balance can be carried forward from year to year. There is no “use it or lose it” rule, except as described in the Forfeiture of Your Special Fund Account section on page 124.

You cannot make self-payments into your Special Fund Account. If you make self-payments under the Plan’s regular eligibility rules, no amount of that payment will be credited to your Special Fund Account. However, if you or your Eligible Dependent's coverage ends because of a COBRA qualifying event, you may continue Special Fund coverage if you elect COBRA in lieu of self-payments.

Access to Funds

Eligible Employees

You shall have access to the funds accumulated in your Account to reimburse Special Fund Covered Expenses that you or your Eligible Dependents incur after you become eligible to participate in the Plan and Special Fund. Your Eligible Dependents must be Covered Individuals (on a primary or secondary basis) for the Special Fund to reimburse expenses incurred on their behalf.

Eligible Retirees

You shall have access to the funds accumulated in your Account to reimburse Special Fund Covered Expenses that you or your Eligible Dependents incur while covered under the Special Fund.

Eligible Dependents

You shall have access to the funds accumulated in the Eligible Employee's or Eligible Retiree's Account upon the death of the Eligible Employee or Eligible Retiree to reimburse Special Fund Covered Expenses that you incur while covered under the Special Fund.

Special Fund Covered Expenses

You may receive reimbursement from your Account for Special Fund Covered Expenses incurred while you or your Eligible Dependents are covered under the Special Fund. An expense is "incurred" when you or your Eligible Dependent is furnished the medical care or service, not when you pay for the medical care or service. However, amounts paid in advance for orthodontia will be deemed incurred to the extent permitted by the Internal Revenue Service ("IRS"). Whether an individual is an Eligible Dependent whose medical expenses can be reimbursed by the Special Fund is determined at the time the expense is incurred. You cannot be reimbursed for any Special Fund Covered Expenses incurred before you were covered by the Special Fund.

The following list identifies some of the common health related expenses that the IRS considers to be Deductible expenses and that qualify as Special Fund Covered Expenses. These expenses are eligible for reimbursement through your Special Fund provided that you have not been reimbursed for them through any other benefits Plan. Some expenses require a prescription, a letter of medical necessity or Physician's directive. For more information on what expenses may be reimbursable under the Special Fund, you should refer to IRS Publication 502 available at www.irs.gov.

Eligible Health Care Expenses

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (when necessary for relief from an allergy or difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (for relief of sickness/disability)
- Birth control pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Breast pumps and other breast-feeding supplies that assist lactation
- Cardiographs
- Chiropractor
- Christian Science Practitioner
- Contact lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental treatment
- Dental x-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription and over-the-counter for treatment of a medical condition)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a Physician
- FICA and FUTA tax paid for medical care service provided by a nurse or other attendant
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Hearing aids and batteries
- High blood pressure monitor
- Hospital bills
- Hydrotherapy
- Insulin treatments
- Lab tests
- Lasik eye surgery
- Lead paint removal
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist services
- Nursing services (including board and meals for the attendant)
- Obstetrician services
- Operating room costs
- Ophthalmologist services
- Optician services
- Optometrist services
- Oral surgery
- Organ transplants (including donor's expenses)
- Orthopedic shoes
- Orthopedist services
- Osteopath services
- Over-the-counter medications
- Oxygen and oxygen equipment
- Pediatrician services
- Physician services
- Physiotherapist services
- Podiatrist services
- Postnatal treatments
- Practical nurse medical services
- Prenatal care
- Prescription medicines
- Psychiatrist services
- Psychoanalyst services
- Psychologist services
- Psychotherapy
- Radium therapy
- Registered nurse services
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon services
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (for health care)
- Ultra-violet ray treatment for medical reasons
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Over-the-Counter Drugs

Over-the-Counter ("OTC") drugs include many drugs that used to be prescription drugs, such as Claritin and Advil, as well as items like cold or cough medicine, pain relievers, allergy medications, and antacids. OTC items that are merely beneficial to the general health of an individual, such as toiletries, (such as toothpaste, mouthwash, etc.), and cosmetics (such as face cream) are not Special Fund Covered Expenses. **The following lists some common OTC drugs that may be Special Fund Covered Expenses**. As with all other expenses, you will need to save your receipts for these items and send them in when you submit your claim reimbursement form. The Plan requires proper substantiation for each item purchased to show that they are being used to alleviate or treat personal injuries or sickness for you and your Dependents(s).

Examples of "Eligible Over the Counter Reimbursable Medical Expenses

- Allergy Relief, such as oral medications, nasal sprays, and patches
- Analgesics, such as fever and pain reducers like Aspirin, Tylenol & Ibuprofen
- Antacids and Heartburn Relief, such as Alka-Seltzer, Mylanta, & Milk of Magnesia
- Antibiotic Ointments
- Anti-itch & Hydrocortisone creams
- Arthritis pain relieving creams
- Athletes Foot Treatment, such as nail & foot anti-fungal creams
- Cold medicines, such as tablets, syrups, drops & lozenges
- Feminine Care relating to treatment of vaginal infections
- First Aid, such as pain-relieving creams
- Laxatives
- Motion Sickness, such as Dramamine, patches, & bracelets
- Shampoo Treatment relating to treatment of psoriasis, lice
- Smoking Cessation Relief, such as patches, gum
- Stomach & Digestive Relief, such as Pepto-Bismol, Imodium, Colace, & Lactaid
- Tooth & Mouth Pain Relief, such as Orajel, Anbesol
- Urinary Pain Relief
- Wart Removal Medication

Eligible Premium Expenses

You can use your Account to make self-payments for active, Retiree, surviving Dependent spouse, spouse or COBRA coverage, but only if your Account balance is sufficient to pay the full amount due. If there is not enough in your Account to make a full self-payment, your reimbursement request will not be honored, and you will have to make the payment by check or money order. If you make a self-payment from your Special Fund Account, and then you become entitled to a refund, the refund will be reimbursed to your Account.

You may also use your Special Fund Account to reimburse the following premium expenses, to the extent they are not, and could not be, deducted pretax through a Code section 125 cafeteria Plan:

- Qualified long-term care insurance (up to certain limits)
- Dental Insurance premiums
- Vision Insurance premiums
- Medicare Part B (Retirees and Dependents only)
- Medicare Part D (Retirees and Dependents only)
- Medicare Supplement policies (Retirees and Dependents only)
- Group Medicare Advantage premiums (Retirees and Dependents only)

- Group health Plan premiums (Retirees and Dependents only)

Examples of Non-Eligible Health Care Expenses

- Babysitting, Childcare for a normal, healthy baby
- Charges incurred by a person not covered by the Plan
- Child or Dependent care
- Controlled Substances – *i.e.*, marijuana
- Cosmetic Services/Procedures (unless necessary to restore normal functioning)
- Dancing or Swimming Lessons (even if they are recommended by a Doctor)
- Diaper Service
- Electrolysis, Hair Removal, Hair Transplant
- Environmental devices such as air conditioners, air purifiers or humidifiers
- Expenses incurred by a person who is not a participant in the Plan, including a family member who does not meet the Plan's definition of Dependent or a Child who exceeds the age limit
- Expenses reimbursed by some other source
- Flexible Spending Account (FSA, MSA, HSA, WRA)
- Funeral Expenses
- Future Medical Care (except orthodontia)
- Health Club Dues (not related to a particular medical condition)
- Health Coverage Tax Credit
- Household Help (even if prescribed by a Doctor)
- Illegal Operations & Treatments
- Insurance Premiums, except as specifically noted above
- Maternity Clothes
- Medicines & Drugs from other countries
- Non-prescription Drugs & Medicines
- Nutritional Supplements
- Personal Use Items
- Sales tax, or shipping and handling fees
- Student health insurance in the student's name
- Teeth Whitening
- Weight Loss Program

The list of covered expenses and any of the Special Fund's rules and procedures can be changed at any time by the Board of Trustees.

How to Use Your Special Fund Account

You have several options for using your Special Fund Account. You can use your Special Fund debit card ("Healthcare Card") to directly pay your health care provider or vendor at the time of the service or sale. You can request reimbursement for Special Fund Covered Expenses using the Plan Office/WexHealth Special Fund mobile application for your Healthcare Card. You can also request reimbursement for a Special Fund Covered Expense through the Special Fund Account Consumer Portal or by completing a Special Fund Payment Request form and returning it to the Plan Office.

Contact the Plan Office if you have questions about your Healthcare Card, the Special Fund mobile application or the Special Fund Account Consumer Portal.

Healthcare Card

You will receive a Healthcare Card that you can use at the point-of-service or point-of-sale to pay for Special Fund Covered Expenses out of your Special Fund Account. The Healthcare Card is provided only as a way

for you to pay for Special Fund Covered Expenses for you or your Eligible Dependents; the Healthcare Card is not a credit card.

You should keep copies of substantiating documentation (*e.g.*, itemized receipts, prescriptions, invoices and EOBs) for all expenses paid for with your Healthcare Card. Certain claims paid with your Healthcare Card can be automatically substantiated at the point of sale, meaning you do not need to submit additional supporting documentation to show it was an eligible expense. However, not all expenses paid with your Healthcare Card can be automatically substantiated. You must manually substantiate any Healthcare Card purchases that are not automatically substantiated. When applicable, the Plan Office will send a letter to you requesting supporting documentation. You can also check if a claim requires additional documentation by logging onto the Special Fund Account Consumer Portal at https://ibewmichigan.lh1ondemand.com/

A third party (*e.g.*, an insurance company, merchant or health care provider) must produce the documentation required for substantiation. For example, for a dental claim, the EOB that Delta Dental mails to you generally contains all the required information and can be used to manually substantiate the claim. Credit card receipts, cancelled checks or a participant's self-substantiation are generally not an acceptable form of substantiation. All receipts and documentation you submit must include the following five pieces of information:

1. Patient name;

2. Date of purchase or service;

3. Detailed description of purchase or service;

4. Patient portion or amount owed; and

5. Provider or merchant name.

If you do not fully substantiate your outstanding Healthcare Card expenses or if the Healthcare Card purchase and substantiating documentation do not qualify as a Special Fund Covered Expense, the Plan will take certain corrective actions. Such actions may include deactivating your Healthcare Card until the improper payment is repaid, offsetting the improper payment against future Special Fund claims or, ultimately, treating the improper payment as a taxable distribution includable in your gross income.

Electronic Reimbursement Request

You can file a claim online using the Special Fund Account Consumer Portal athttps://ibewmichigan.lh1ondemand.com/ You can also request reimbursement using the Special Fund mobile application for your Healthcare Card.

Paper Reimbursement Request

You can submit paper claims to request reimbursement by completing and signing a Special Fund Payment Request form and returning it to the Plan Office. A completed reimbursement request includes:

1. The date of request;

2. Your Social Security number:

3. Your Local Union number;

4. Your name and address;

5. The amount of each type of expense requested:

6. The total amount requested; and

7. Your signature.

The form authorizes the Plan Office to make a payment from your Account. You can obtain forms from the Plan Office, your Local Union or from the Plan's website. Incomplete Special Fund Request forms will NOT be processed.

If you submit paper claims, reimbursement payments will be issued to you by check.

With the Special Fund Payment Request form or a claim submitted through the Special Fund Account Consumer Portal or Special Fund mobile application, you must submit substantiation, which could include copies of the following documents (as applicable):

1. the itemized bills (which state the provider's name and address, patient's name, date of service, services provided, and charges for the services);

2. EOBs from BCBSM or, if you or your Eligible Dependents have multiple health Plans/medical insurances, EOBs from all Plans;

3. The insurance premium statement, name of the insured, coverage period and proof that the insurance premium was paid;

4. Prescription slip;

5. Cash register receipts for (OTC) Special Fund Covered Expenses. These receipts must have the name of the product, the date of purchase and the amount imprinted by the cash register. Non-imprinted, or hand-annotated cash register receipts will NOT be accepted. It is your responsibility to purchase these products at stores that properly document the name of the product purchased.

You may submit a reimbursement request at any time, but the minimum amount requested should be $50. If you accumulate less than $50 of reimburse able expenses in a year, you may request reimbursement at the end of the year. A reimbursement request will be honored only if it is submitted within three years of the date the expense was incurred.

You will be reimbursed for the expense if you have a sufficient Account balance. If you do not have a sufficient amount in your Account to cover the reimbursement request, you may resubmit the remaining expense for reimbursement at a later date but no later than three years after the date of service.

Reimbursement requests can be made by you or your spouse. Reimbursements will be made payable only to you, not to any provider.

Self-Payment and COBRA Expenses

If you wish to use your Account to make a self-payment, you must submit an Authorization for Self-Payment Transfer From Special Fund form and return it to the Plan Office. A completed form includes your Social Security number, local Union number, name and address and your signature. The form authorizes the Plan Office to make a payment from your Account. You can obtain forms from the Plan Office, your Local Union or from the Plan's website. Incomplete forms will NOT be processed.

If you do not have enough in your Account to make the self-payment you have requested, you will be notified by return mail. You will then have to make your payment by check or money order before the regular due date. *The due date will not be extended and you cannot make a partial self-payment from the Special Fund Account.*

Forfeiture of Your Special Fund Account

Your Special Fund Account will be forfeited to the Plan in the following circumstances:

Upon Death

Upon your death, the entire balance of your Account will become available to your Eligible Dependents. Your Eligible Dependents may request reimbursement from your Account until the Account balance is zero, the

Account is forfeited for the reasons below, or the Plan terminates. If you have no Eligible Dependents, your Account balance will be forfeited to the Plan upon your death.

Forfeiture of Inactive Account

If your Account has a balance less than $100 and has had no hourly contributions or withdrawals for two Calendar Years (four years for balances of $100 or more) your Account will be closed, and the balance will be forfeited to the Plan.

Forfeiture of Account Due to Opt-Out

If prior to September 1, 2017, you or, upon your death, your Eligible Dependent elected to opt-out of the Special Fund (as described below), the balance was be forfeited to the Plan.

Forfeiture Due to Non-Contributory Employment

Your Account will be terminated and forfeited to the Plan if you perform work with a non-Contributing Employer that would qualify as Covered Employment if it had been performed for a Contributing Employer within the jurisdiction of the Plan. However, if you return to Covered Employment with a Contributing Employer within the following time periods, your Account will be reinstated:

1. For Account balances of less than $100 – twenty-four months following the date your coverage terminates.

2. For Account balances of $100 or more – forty-eight months following the date your coverage terminates.

Opting-Out of Your Special Fund Account

You will be given an opportunity to opt-out of Special Fund coverage and waive future reimbursements from your Account at the following times:

1. Annually, while you remain a Covered Individual;

2. Upon termination of eligibility for Plan coverage; and

3. Upon becoming eligible for Retiree coverage.

4. Additionally, upon your death, your Eligible Dependents will be given an opportunity to opt-out of Special Fund coverage and waive future reimbursements from your Account.

If you or, upon your death, your Eligible Dependents elect to opt-out of your Special Fund Account, your Account will be frozen. While your Account is frozen, any Special Fund contributions received on your behalf will be forfeited to the Plan. Your Account will be reinstated at the following times:

1. For an annual opt-out, the earlier of (1) the January 1, following the 12-month period to which your opt-out applied, unless you elect to opt-out for a subsequent twelve-month period or (2) your death.

2. For an opt-out upon termination of eligibility for Plan coverage, the date you regain Plan and Special Fund eligibility.

3. For an opt-out upon becoming eligible for Retiree coverage, the earlier of (1) the January 1, following the 12-month period to which your opt-out applied, unless you elect to opt-out for a subsequent twelve-month period or (2) your death.

4. For an opt-out upon your death, the January 1, following the 12-month period to which your opt-out applied unless your Eligible Dependents elect to opt-out for a subsequent twelve-month period. Any amounts remaining in your Account upon your Eligible Dependents' death will be forfeited to the Plan.

Coordination of Benefits and Ordering Rules

The Special Fund shall not be considered a group health Plan for coordination of benefits purposes under the Plan's Coordination of Benefits provisions, and its reimbursement benefits shall not be taken into Account when determining other benefits payable under this Plan or benefits payable under any other health Plan except for Medicare.

The use of benefits under the Special Fund may be restricted under some circumstances for active Employees or their Eligible Dependents who are enrolled in Medicare.

If a Special Fund Covered Expense is also covered by the Plan, the expense must be submitted to the Plan first.

If you or your Eligible Dependent is covered under another health reimbursement arrangement or health flexible spending account, Special Fund Covered Expenses must be submitted to the other health reimbursement arrangement or health flexible spending Account before they are submitted to the Special Fund.

Other Rules Governing Your Special Fund Account

Neither you nor your Eligible Dependents are vested in your Special Fund Account balances.

The total combined reimbursement from all benefit/insurance Plans when added to the amount of the Special Fund Account reimbursement cannot exceed 100% of the billed amount.

The Board of Trustees reserves the right to eliminate or modify this program at any time and in their sole discretion.

Continuation Of Account Under COBRA

If you and/or your Dependent's coverage ends due to a COBRA qualifying event, each Qualified Beneficiary will be given the option of electing to continue coverage under the Special Fund if the Qualified Beneficiary elects COBRA Continuation Coverage for health care benefits.

Claims and Appeals Procedures

Health claims and most prescription drug claims are handled by BCBSM. Dental claims, if applicable, are handled by Delta Dental. The Plan Office processes all other claims. For benefits provided under the fully insured policies and the Medicare Plus Blue Group PPO, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits.

Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not submitted by the provider, medical and most prescription drug claims should be submitted to BCBSM. Dental claims should be submitted to Delta Dental. All other claims for benefits (including eligibility claims) should be submitted to the Plan Office as follows:

Special Fund Claims

You can submit a Special Fund claim through the use of your Healthcare Card at the time of the sale or service. To request a reimbursement from your Special Fund Account, you can complete a Special Fund Payment Request form and return it, along with copies of the itemized receipts or EOBs from BCBSM, to the Plan Office. You can obtain this form from the Plan Office, your Local Union or the Plan's website. Alternatively, you can submit claims using the Special Fund mobile application or the Special Fund Account Consumer Portal. For more information, see "How to Use Your Special Fund Account" on page 122.

Claims for Weekly Disability Benefits

If you have a claim for Weekly Disability Benefits, call the Plan Office for the proper forms and procedures.

Death and Accidental Death and Dismemberment Benefits

If you have a claim for a Death Benefit or AD&D Benefits call the Plan Office for the proper forms.

Prescription Drug Claims

The only time you should file a claim for a prescription is when you use a nonparticipating pharmacy or when coordination of benefits applies. If you go to a pharmacy that does not participate in the Plan's pharmacy network you must pay the full cost of the prescription and file a claim with the Plan Office. If another health Plan pays primary benefits for prescriptions for a family member, you may file a claim with the Plan Office after the other Plan has paid its benefits and sends the family member an EOB. Send a copy of the EOB and the pharmacy receipt showing the drug name, the Doctor and the cost to the Plan Office. Cash register receipts are not acceptable.

Claim Filing Time Limit

Claims submitted to the Plan Office must be received by within the following timeframes or they will be denied:

Type of Claim	Filing Deadline
Special Fund Claims	36 months from the date the expense is incurred
Death Benefits	12 months from the Employee's date of death
All other claims	15 months from the date the expense is incurred

The claim filing limit for claims submitted to BCBSM is described in the Benefit Component documents.

Claims for Automobile-Related Accidents and Motorcycle Accidents

No-fault Automobile Accidents (for Non-Michigan Residents)	For non-Michigan residents, Plan coverage is secondary to no-fault automobile insurance for all services related to an injury which is a direct or indirect result of an automobile accident, including but not limited to automobiles, buses, trucks, etc. Plan coverage is available only when benefits do not duplicate those available under your no-fault automobile insurance policy. Payment under the Plan, when combined with any payment you receive under your automobile insurance policy, will not be more than 100% of the BCBSM Approved Amount for covered services.
Motorcycle Accidents	Plan coverage will be secondary to any motorcycle insurance whether or not the individual is wearing a helmet and whether or not the individual maintains medical benefit motorcycle coverage (*e.g.* Plan coverage is secondary when an individual was wearing a helmet at the time of an accident and maintains medical benefit motorcycle insurance coverage). If an individual does not maintain the medical benefit motorcycle insurance coverage required by law to ride without a helmet (currently $20,000), the Plan will not pay any amount that would have been covered by the mandatory motorcycle insurance. Instead, the mandatory motorcycle insurance coverage will apply like a Deductible and the Plan will provide benefits only for amounts that exceed the required coverage ($20,000).

Claims Review and Appeal Procedures

General

No Eligible Employee, Eligible Retiree, Eligible Dependent or other beneficiary shall have any right or claim to benefits from the Plan, except as specified in this section. Any dispute as to eligibility, type, amount or duration of benefit under the Plan or any amendment or modification thereof shall be resolved by the Board of Trustees under and pursuant to the Plan and the Trust Agreement. You may authorize a representative to act on your behalf, provided any such authorization must be in writing and submitted to the Trustees. You must notify the Plan in writing of your representative's name, address, and telephone number. You may, at your own expense, have legal representation at any stage of review. Regardless of the outcome of your appeal, neither the Board of Trustees nor the Plan will be responsible for paying any legal expenses that you incur during the course of your appeal.

Important Definitions

For purposes of the procedures set forth below, the following terms have special meanings:

Claim. A request for benefits under the Plan. An inquiry about whether a Plan covers a service is not a claim for benefits.

Claim Administrator. The claims administrator varies depending on the benefit. For medical and most prescription drug claims, BCBSM is the Claim Administrator. For dental claims, Delta Dental is the Claim Administrator. The Board of Trustees, or its delegate, is the Claim Administrator for all other claims for benefits (including eligibility claims). Additionally, the Board of Trustees, or its delegate, is the Claim Administrator for the second level appeal of Pre-Service Health Claims and Post-Service Health Claims.

Concurrent Claims. A request to extend the duration or number of treatments or a reduction or termination of a previously approved ongoing course of treatment, other than by Plan amendment or Plan termination

Denial or Adverse Benefit Determination. Any of the following:

1. A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including your or a Dependent's eligibility to participate in this Plan, or a determination that a benefit is not a covered benefit;

2. A denial, reduction or termination of, or a failure to provide or make payment for a benefit resulting from the application of any utilization review, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigative or not Medically Necessary or appropriate; or

3. A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

Pre-Service Health Claims. A claim for medical care or treatment for which the Plan requires approval in advance of obtaining medical care, for example, pre-certification of a Hospital stay.

Post-Service Health Claims. A claim submitted after you receive treatment from Physician. All Special Fund claims are Post-Service Claims**.**

Rescission of Coverage. The retroactive cancellation of coverage. However, if your coverage is retroactively canceled or discontinued for the following reasons, the cancellation or discontinuance of coverage is not considered a rescission:

1. When attributable to a delay in administrative recordkeeping if you do not pay any premiums for coverage after termination of employment;

2. When attributable to a failure to timely pay required premiums or contribution toward the cost of coverage; or

3. Effective retroactively to the date of divorce.

Urgent Health Claims. Claims for medical care or treatment that require expedited consideration in order to avoid seriously jeopardizing your life or health or subjecting you to severe pain that cannot be adequately managed without care or treatment. Whether a claim is an Urgent Health Care Claim will be determined by the Plan, deferring to the judgment of a Physician with knowledge your condition. Urgent Health Claims are a subset of Pre-Service Health Claims.

Avoiding Conflicts of Interest

Claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

Initial Decision on Claims

Timing of Denial

The deadline for the Claim Administrator to make an initial decision on a claim is:

Urgent Health Claim - As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim.

Pre-Service Health Claim - 15 days after receiving the initial claim.

Post-Service Health Claim - 30 days after receiving the initial claim.

Concurrent Claim - Within 24 hours orally and then furnish a written notification for urgent concurrent care claims. For all other concurrent care claims, you will receive the Claims Administrator's decision within the timeframes for pre- or post-service claims.

Weekly Disability Benefit Claim - 45 days after receiving the initial claim.

All Other Claims - 90 days after receiving the initial claim.

Extensions of Time

The Claim Administrator may extend the deadlines noted above in the following instances:

Missing Information

If, during the review, additional information is required from you to process your claim, the Claim Administrator will notify you as follows:

For Urgent Health Claims – Within 24 hours of submitting the claim. You will have at least 48 hours to provide the missing information. In such a case, the Claim Administrator will inform you of its decision no later than 48 hours after the additional information is submitted.

For Pre-Service Health Claims – Within 15 days of submitting the claim. You will have 45 days to provide the missing information, and your claim shall be denied if you do not provide the information in the 45-day period. After you provide the required information, the Claim Administrator will issue a written notice of its decision within 15 days.

For Post-Service Health Claims – Within 30 days of submitting the claim. You will have 45 days to provide the missing information, and your claim shall be denied if you do not provide the information in the 45-day period. After you provide the required information, the Claim Administrator will issue a written notice of its decision within 15 days.

For Weekly Disability Benefit Claims – Within 45 days of submitting the claim. You will have 45 days to provide the missing information, and your claim shall be denied if you do not provide the information in the

45-day period. After you provide the required information, the Claim Administrator will issue a written notice of its decision within 30 days.

Extensions for Matters Beyond the Claim Administrator's Control

The Claim Administrator may extend the review period for matters beyond its control as follows:

For Pre-Service Health Claims – Within 15 days of submitting the claim. The Claim Administrator will provide you with a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 15-day benefit determination period, by which you can expect to receive a decision.

For Post-Service Health Claims – Within 30 days of submitting the claim. The Claim Administrator will provide you with a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 15-day benefit determination period, by which you can expect to receive a decision.

For Weekly Disability Benefit Claims – Within 45 days of submitting the claim. The Claim Administrator will provide you with a notice that explains the special circumstances requiring a delay in the decision and sets a date, no later than 30 days after the ending of the initial 45-day benefit determination period, by which you can expect to receive a decision. If special circumstances again require more time to review a claim, a second 30-day extension may be taken subject to written notice within the initial 30-day extension.

For all other Claims – Within 90 days of submitting the claim. The Claim Administrator will provide you with a notice that explains the special circumstances requiring a delay in the decision and sets a date, no later than 90 days after the ending of the initial 90-day benefit determination period, by which you can expect to receive a decision.

Initial Claim Denial (or "Adverse Benefit Determination")

If your claim for benefits is partially or wholly denied, you (or your Dependent or authorized legal representative) will receive a notice from the Claim Administrator that includes the following information:

1. the specific reasons for the denial;

2. the specific Plan provision(s) on which the decision was based;

3. if applicable, what additional material or information is necessary to complete the claim and the steps that must be taken to have claim denial reviewed and the reason why such material or information is necessary and explaining the initial decision shall be a final decision unless it is appealed as described in the Plan;

4. a description of available internal appeal process; and

5. a statement of your right to bring a civil action under ERISA after further denial on appeal.

Certain types of claim denial notices will include additional information:

<u>Health Claims</u>

1. if the denial was based on medical necessity, experimental nature of treatment or similar matter, a statement that you may request a copy of that clinical judgement free of charge; and

2. the internal rule or similar guideline relied upon in denying the claim and offer a copy free of charge of the same upon request;

<u>Health Claims *Except* Dental and Vision</u>

1. information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable);

2. the denial code and corresponding meaning;

3. a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

4. a description of how to initiate the external review process for an adverse benefit determination if the timeframe for completion of the internal appeal would jeopardize your life or health or would jeopardize your ability to regain maximum function;

5. a statement of your right to request an external review with an independent review organization following denial on appeal;

6. If applicable, the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and

7. If applicable, a notice in any applicable non-English language describing how to access the Plan's language services.

Weekly Disability Benefit Claims

1. an explanation of the basis for disagreeing with or not following the views of a health care professional or vocational professional or vocational professional who treated or evaluated you, a medical or vocational expert whose advice was solicited by the Plan, the Board of Trustees or Committee in connection with your claim or a disability determination made by the Social Security Administration;

2. copies of any internal rule, guideline, protocol or similar criteria relied upon in denying your claim or a statement that such rule, guideline, protocol or similar criteria do not exist;

3. if the denial was based on medical necessity, experimental nature of treatment or similar matter, a statement that you may request a copy of that clinical judgement free of charge;

4. information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);

5. A statement that you are entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to your claim upon request, free of charge;

6. The time frame for bringing a civil action under ERISA.

Review of Denied Claim

How to Request a Review of a Denied Claim

If you want to have the denied claim reviewed, you must send a written request for a review of the claim denial to the Claim Administrator no later than 180 days after the date of the notice of denial. You may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue within the 180-day deadline.

Full and Fair Review

The Claim Administrator will review the denied claim according to the terms and conditions of the Plan. The review shall consider all comments, documents, records and other information you submit, regardless of whether the information was submitted or considered in the initial determination. You have the right to access and copy all documents, records and other information relevant to the claim (information relied upon, submitted, considered or generated in the review or demonstrating compliance with the claims processing requirements).

For health and weekly disability benefit claims, the Claim Administrator will:

1. If the decision requires medical judgment, consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

2. Provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claim Administrator (or at the direction of the Claim Administrator) in connection with your claim as soon as possible and sufficiently in advance of the Claim Administrator's final decision, to give you a reasonable opportunity to respond; and

3. Provide you, free of charge, with any new or additional rationale for denying your claim as soon as possible and sufficiently in advance of the Claim Administrator's final decision, to give you a reasonable opportunity to respond.

If the Claim Administrator receives new or additional evidence related to a health claim so late that you will not have a reasonable opportunity to respond, the time period for the Claim Administrator to issue its decision will be tolled to provide you with time to respond. The Claim Administrator will issue its decision as soon as reasonably practical after you respond or the time period you were provided to respond has ended.

Two-Level Appeal Process for Health Claims

Except with respect to Urgent Care Claims, the Plan follows a two-step appeal process for benefits administered by BCBSM. BCBSM is the Claims Administrator for the initial review of denied Pre-Service Health Claims and Post-Service Health Claims. If BCBSM partially or wholly denies your appeal, you may submit your appeal to the Trustees for a second review of the appeal. If you wish to have an appeal reviewed, you must send a written request to the attention of the Trustees at Plan Office no later than 60 days after the date of the notice in the appeal denial. You may submit additional materials for the Trustees' consideration on review, including a written explanation of the issues and comments on the issue. The Trustees will otherwise follow the same full and fair review process identified above. If your second appeal is denied, you may seek external review of your claim as explained below.

With respect to Urgent Health Claims, BCBSM serves as the sole Claims Administrator on appeal. If your Urgent Health Claim appeal is wholly or partially denied, you will have the option to appeal this decision to the Trustees. This is a voluntary appeal right. In addition to the voluntary appeal to the Trustees, you may seek external review of your appeal as explained below.

Timing of Appeal Denials

The deadline for the Claim Administrator to make a final decision on an appeal is:

Urgent Health Claim – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving the appeal.

Pre-Service Health Claim –

1. Benefits administered by BCBSM –

   - 15 days after receipt of the appeal for initial review
   - 15 days after receipt of request for a second appeal

2. Benefits administered by the Plan – 30 days after the Plan's receipt of the appeal.

Post-Service Health Claims –

1. Benefits administered by BCBSM –

   - 30 days after receipt of the appeal for initial review
   - 30 days after receipt of request for a second appeal

2. Benefits administered by the Plan – 5 days after the first quarterly meeting of the Board of Trustees, or a Committee designated by the Trustees, following receipt of the appeal. If the appeal is received

within 30 days of the quarterly meeting, the appeal will be reviewed at the second quarterly meeting following receipt of the appeal.

Concurrent Claims – prior to termination of the previously approved course of treatment.

Weekly Disability Benefit Claims – 5 days after the first quarterly meeting of the Board of Trustees, or a Committee designated by the Trustees, following receipt of the appeal. If the appeal is received within 30 days of the quarterly meeting, the appeal will be reviewed at the second quarterly meeting following receipt of the appeal.

All Other Claims – 5 days after the first quarterly meeting of the Board of Trustees following receipt of the appeal. If the appeal is received within 30 days of the quarterly meeting, the appeal will be reviewed at the second quarterly meeting following receipt of the appeal.

Content of Denial Notice on Review

If all or part of your claim is denied on appeal, you (or your Dependent or authorized legal representative) will receive a written notice that includes the following information:

1. The specific reasons for the denial;

2. The specific Plan provision(s) on which the decision was based;

3. A statement that you are entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to your claim upon request, free of charge;

4. If applicable, a statement describing any additional, voluntary appeal and your right to obtain information about the voluntary appeal procedures;

5. A statement of your right to bring a civil action under ERISA.

Certain types of appeal denial notices will include additional information:

Health Claims

1. the internal rule or similar guideline relied upon in denying the claim and offer a copy free of charge of the same upon request;

2. if the denial was based on medical necessity, experimental nature of treatment or similar matter, a statement that you may request a copy of that clinical judgement free of charge;

Health Claims Except Dental and Vision

1. a discussion of the Claim Administrator's decision;

2. information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), denial code and corresponding meaning);

3. a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meaning;

4. a statement of your right to request an external review with an independent review organization following denial on appeal.

5. If applicable, the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and

6. If applicable, a notice in any applicable non-English language describing how to access the Plan's language services.

1. an explanation of the basis for disagreeing with or not following the views of a health care professional or vocational professional or vocational professional who treated or evaluated you, a medical or vocational expert whose advice was solicited by the Plan, the Board of Trustees or Committee in connection with your claim or a disability determination made by the Social Security Administration;

2. copies of any internal rule, guideline, protocol or similar criteria relied upon in denying your claim or a statement that no such rule, guideline, protocol or similar criteria do not exist;

3. if the denial was based on medical necessity, experimental nature of treatment or similar matter, a statement that you may request a copy of that clinical judgement free of charge;

4. information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);

5. the calendar date by which any lawsuit must be filed.

External Review of a Denied Health Claim

Right to Request External Review

The Plan offers you the right to request an external review of certain denied Health Claims and rescissions of coverage. The Plan will offer this right in accordance with and to the extent required by available guidance issued by the Departments of Health and Human Services, and Labor and the Internal Review Service.

Claims Eligible For External Review

Health Claims (other than Dental and Vision claims) that involve medical judgment and rescissions of coverage are eligible for external review. Weekly Disability Benefits Claims and all other welfare benefit claims are not eligible for external review.

How to Request a Review of a Denied Health Claim

Pre-Service Health Claim and Post-Service Health Claims

If you want to have the denied Pre-Service Health Claim or Post-Service Health Claim reviewed, you must send a written request for an external review of the claim denial to the Plan Office no later than 4 months after the date you receive the notice of the denial of the Health Claim on your second appeal. You may submit additional materials for consideration on review, including a written explanation of the issues and comments on the issue.

Urgent Health Claim

If you want to have the denied Urgent Care Health Claim reviewed, you must send a written request for an external review of the claim denial to BCBSM no later than 4 months after the date you receive the notice of the denial of the Health Claim on your initial appeal. You may submit additional materials for consideration on review, including a written explanation of the issues and comments on the issue.

In certain situations, you may be able to request an expedited external review while simultaneously pursuing an expedited appeal through the internal appeal process. You, or your authorized representative, should contact BCBSM for expedited external review.

Note: You have the option of appealing to the Trustees for a second review; however, because this is a voluntary appeal right, the period for submitting a request for an external review begins to run following your receipt of the initial appeal denial.

Further Action

In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or its Trustees may be filed until the matter has been submitted for review in accordance with these claims appeal provisions.

Further, in the event a claim has been submitted for review in accordance with such provisions and the claim has again been denied, no lawsuit or other action against the Plan or its Trustees may be filed after twelve months from the date you have been given written notice of the Trustees' decision on his or her appeal. If the time limitation in this section of the Plan is less than that required by Federal law, such limitation is hereby extended to conform to the minimum period permitted by Federal law. All actions must be commenced in the Federal District Court in either the Eastern or Western District of Michigan.

Discretion of Trustees and Trustee Authority

The Board of Trustees has full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Its decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

In addition, the Board of Trustees has full discretion and authority to interpret the terms of all documents establishing this Plan, including but not limited to the rules of eligibility. The Board of Trustees has full power and authority to increase, reduce or eliminate benefits and to change the eligibility rules and other provisions of the Plan as in their discretion may be proper or necessary for the sound and efficient administration of the Trust Fund, provided that such changes are not inconsistent with the law or with the provisions of the Trust Agreement. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable while they are in effect. The right to change or eliminate any and all aspects of benefits provided under the Plan, including those for Retirees and their Dependents, is a right specifically reserved to the Trustees. The Trustees have the authority to amend or terminate such benefits and to initiate or increase self-payments for the coverage at any time. Any such change shall be effective even though an Employee has already become a Retiree.

Any amendment made by the Trustees will be reduced to writing and may be effective prospectively or, to the extent consistent with the ACA, retrospectively. Any change to this booklet is an amendment to the Plan. Notices of any changes or deletions of the information in this booklet will be provided to each participant, but some changes may take effect before you are notified of a change. Before incurring any non-emergency expense, you should contact the Plan Office to confirm your current entitlement to coverage.

Only the full Board of Trustees is authorized to interpret the Plan. The Trustees' interpretation will be 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 that such decision is to be upheld unless it is determined to be arbitrary or capricious. No agent, representative, officer, or other person from the Union or an Employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents.

If you have questions about your eligibility or a claim, contact the Plan Office. Matters that are not clear, or which need interpretation, will be referred to the Trustees.

Coordination of Benefits

Benefits are coordinated when you and your Dependents are covered by This Plan as well as by another group health Plan (such as your spouse's Plan). Coordination allows benefits to be paid by two or more Plans, up to but not to exceed 100% of the allowable expenses on the claim.

General C.O.B. Information

Benefits are coordinated on all Employee (active or retired) and Dependent claims. C.O.B. applies to all benefits except Weekly Disability Benefits, Death Benefits and AD&D Benefits.

You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits you are entitled to from the other source(s).

This Plan will not pay benefits for expenses which would have been covered by the other Plan, but which are not covered because the person failed to take the action required under the rules of the other Plan to qualify for benefits. This could occur in a case where the person was required by the other Plan to use certain Doctors or Hospitals under an HMO or PPO Plan. Or it could occur in cases where the person failed to comply with the other Plan's required utilization review or cost containment procedures such as Hospital preadmission

review or certification, second surgical opinions, required preauthorization for benefits or any other required notification or procedure of the other Plan, including failing to file a claim.

If the other Plan refuses to pay benefits according to This Plan's rules, This Plan may continue to pay benefits as if it were primary in consideration of being subrogated to the affected person's rights against the other Plan.

Benefits are paid in C.O.B. for "Allowable Expenses," which are expenses that are eligible to be considered for reimbursement.

Benefits are coordinated with group insurance and group subscriber contracts; uninsured and underinsured arrangements of group or group-type coverage; group or group-type coverage through HMOs and other prepayment group practice and individual practice Plans; group-type contracts; labor management trustee Plans; Union welfare Plans (including This Plan if husband and wife are both Eligible Employees); Employer organization Plans or Employee benefit organization Plans; and any federal or state or other government Plan including Medicare -. If you or anyone in your family is covered under another Plan, you can contact the Plan Office to find out whether that Plan fits the definition of a group Plan.

Definitions Applicable to Coordination of Benefits

The term "Plan," as used in this section, means any Plan providing benefits or services for or by reason of medical care or treatment which benefits or services are provided by:

1. Group or blanket insurance coverage, group Blue Cross and group Blue Shield, or other group prepayment coverage, coverage under a labor-management trustee Plan, Union welfare Plan, Employer organization Plan, or Employee benefit organization Plan, including any federal or state or other governmental Plans or law; or

2. Coverage under any Plan largely tax-supported or otherwise provided for by or through action of any government; or

3. Medicare. For the purposes of this section, the definition of Medicare shall include both Part A and Part B of Medicare, whether or not the Eligible individual is enrolled for both parts.

4. No-fault automobile insurance for non-Michigan Residents, medical benefit motorcycle insurance coverage or other security for payment of benefits or assignment of claims or other governmental Plan or law required by an insurance statute, medical benefit motorcycle insurance coverage statute, or similar legislation in those states where such legislation is in force and allowable by law.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

The term "Allowable Expense," as used in this section, means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person with respect to whom claim is made. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished shall be deemed to be both an Allowable Expense and a benefit paid. The Trustees shall not be required to determine the existence of any Plan or the amount of benefits payable under any Plan except This Plan, and the payment of benefits under This Plan shall be payable under any and all other Plans only to the extent that the Trustees are furnished with information relative to such other Plans by the Employer or Employee or any insurance company or other organization or person.

The term "Claim Determination Period," as used in this section, means a period of one year commencing with a January 1.

The term "Dependent" as used in this section means, with respect to This Plan, any person included within the definition of "Dependent" in the section herein captioned "Definitions" and, with respect to any other Plan, any person who qualifies as a Dependent under such Plan.

Effect on Benefits

The provisions of this section shall apply in determining the benefits as to a person covered under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:

1. The benefits that would be payable under This Plan in the absence of this section; and

2. The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this section shall exceed such Allowable Expenses.

As to any Claim Determination Period with respect to which this section is applicable, the benefits payable under This Plan, in the absence of this section for the Allowable Expenses incurred as to such person during such Claim Determination Period, shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as otherwise provided in this section, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.

If another Plan contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the benefits of This Plan have been determined and the rules set forth below would require This Plan to determine its benefits before such other Plan, then the benefits of such other Plan shall be ignored for the purposes of determining the benefits under This Plan.

Coordination Rules

The rules establishing the order of benefit determination are:

1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person as a Dependent.

2. (With respect to establishing the order of benefit determination on claims for Dependents, other than in the case of a Dependent Child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a Dependent of a person whose date of birth, excluding year of birth, occurs earlier in a Calendar Year, shall be determined before the benefits of a Plan which covers such person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar Year.

3. The benefits of a Plan which covers the person on whose expenses claim is based as a Dependent Child shall be determined as follows in cases where the parents are divorced or legally separated:

    - When there is a court decree which establishes financial responsibility for medical and health care expenses with respect to the Child, the benefits of a Plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the Child as a Dependent Child.

    - In the absence of a court decree establishing financial responsibility for the Child's medical and health care expenses and if the parent with custody of the Child has not remarried, the benefits of a Plan which covers the Child as a Dependent of the parent with custody of the Child shall be determined before the benefits of a Plan which covers the Child as a Dependent of the parent without custody.

    - In the absence of a court decree establishing financial responsibility for the Child's medical and health care expenses, and if the parent with custody of the Child has remarried, the benefits of a Plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that Child as a Dependent of the stepparent, and the benefits of a Plan which covers the Child as a Dependent of the stepparent shall be determined before the benefits of a Plan which covers that Child as the Dependent of the parent without custody.

4. A Plan which covers a person as an Employee who is not laid off, retired, or making continuation coverage payments to the Plan as a former Employee determines its benefits before a Plan which covers that person as a laid off Employee, retired Employee or former Employee making continuation

coverage self-payments. This same rule would hold true if a person is a Dependent of a person covered as both an active Employee and as a laid off/retired/former Employee making continuation coverage self-payments. If the other Plan does not have this rule, and if as a result the Plans do not agree on the order of benefits, this rule is ignored.

5. If the above rules do not establish an order of benefit determination, the benefits of the Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such persons a shorter period of time.

6. In the event that any Dependent Child or Other Dependent of an Eligible Employee is covered under This Plan as an Employee, a claim for such Dependent shall not be coordinated. The claim for such person shall be processed as an Employee.

The benefits of a Plan paid or payable pursuant to a no fault motor vehicle insurance statute, medical benefit motorcycle insurance coverage or similar legislation shall be determined before the benefits of This Plan.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of the C.O.B. provisions of This Plan or any provision of similar purpose of any other Plan, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Trustees deem to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Trustees such information as may be necessary to implement the C.O.B. provisions of This Plan.

Nonrecognition of Benefit Limitations (C.O.B With SubPlans)

Some Plans attempt to avoid responsibility for paying their fair share of benefits when they are primary by invoking a special provision that attempts to shift their fair share of a claim to the secondary Plan. The rule explained below is intended to protect This Plan in the event the primary Plan has one of these cost-shifting rules.

1. If another Plan that is primary in accordance with the order of benefit determination rules contains a provision that modifies, limits or reduces its benefits in a way that shifts additional liability to This Plan, then This Plan shall consider such provision to have no force or effect. In that case, This Plan's benefits will be determined as if the other Pan had paid based on its regular coverage rules for a person without other coverage.

2. If another Plan's rules exclude a person from eligibility because that person is also covered under This Plan, attempts to shift coverage liability to This Plan, or avoids the customary application of This Plan's coordination of benefits rules, then This Plan will consider such rule to have no force or effect.

3. If No. 1 or 2 above apply, This Plan will coordinate its benefits as if the other Plan's cost-shifting rules did not exist and as if the other Plan paid its full regular benefits. If the other Plan's rules cannot be disregarded for a person covered by This Plan on a secondary basis, the maximum benefit payable for such person under This Plan will be $1,000 per Calendar Year.

C.O.B. With Medicare

You are responsible for enrolling in Medicare Part A and Part B when you are eligible to do so. If you are eligible to enroll in Medicare, This Plan will assume that you have enrolled in both Part A and Part B of Medicare and will coordinate benefits as if benefits payable by Medicare have been paid. This means that This Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in both Part A and Part B of Medicare. This applies whether you are eligible to enroll in Medicare due to becoming age 65 or due to disability. It also applies to Dependents who are eligible to enroll in Medicare.

You will not be added to the Medicare Plus Blue Group PPO Program if you are not enrolled in both Part A and Part B of Medicare. This also applies to your Dependents.

C.O.B. With Medicare for Employees and Their Dependents

C.O.B. With Medicare for Persons Under Age 65

If an eligible family member is entitled to Medicare for reasons other than being 65 or older, federal law may require This Plan to pay its benefits first—for example, for a Totally Disabled person. Also, special rules apply to a person who is an ESRD beneficiary under Medicare. Check with the Plan Office or your local Social Security office for more information about this rule.

C.O.B. With Medicare for Age 65 or Over Employees and Their Spouses

If you continue to work after you become age 65 and eligible for Medicare, you are entitled to the same benefits as Employees under age 65 as long as you meet the regular eligibility rules. This Plan will pay its benefits before Medicare pays its benefits.

If your Dependent spouse is age 65 or older and eligible for Medicare while you are still actively working and eligible (regardless of your age), This Plan will pay its normal benefits for your spouse before Medicare pays. If your spouse is covered under her own Plan, your spouse's Plan will pay first, This Plan will pay second, and Medicare will pay last. (Once you retire, benefits will be paid for your spouse as explained in the section below titled “C.O.B. With Medicare for Retirees and Their Dependents.”)

You (and/or your spouse) can decline coverage under This Plan. If you do, Medicare will be your only health care coverage. If you and/or your spouse prefer Medicare as your health care coverage when you are age 65, contact the Plan Office (or your spouse should notify her own Plan). Unless you make such a choice, This Plan will usually continue to pay primary benefits for you (and its normal benefits for your spouse) as long as you stay regularly eligible.

C.O.B. With Medicare for Retirees and Their Dependents

If a Retiree or a Dependent of a Retiree is eligible for the Medicare Plus Blue Group PPO Program, Medicare will pay benefits first on that person’s claims and the Medicare Plus Blue Group PPO Program will pay certain supplementary benefits.

If you or your spouse want information about Medicare enrollment, contact your local Social Security office (before your 65th birthday, if possible).

C.O.B. With No-Fault or Similar Coverage

The benefits of This Plan do not apply to the extent that benefits are paid or payable for Allowable Expenses pursuant to a Plan required by a no fault motor vehicle insurance statute, medical benefit motorcycle insurance coverage statute, or similar legislation; however, where the no fault coverage or medical benefit motorcycle insurance coverage provides a person with less coverage than This Plan would provide in the absence of this provision, the rules in the Section captioned "Effect on Benefits" apply. If a person does not maintain medical benefit motorcycle insurance coverage because the person wears a motorcycle helmet, this section will not apply provided the person was wearing a motorcycle helmet when the accident occurred.

Circumstances Which May Result in A Denial or Loss of Benefits

The Trustees or their representatives are authorized to deny payment of a claim, and the reasons for denial may include one or more of the following:

1. The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred.

2. You didn’t file the claim within the Plan time limits.

3. The expenses that were denied are not covered under the Plan or the expenses were not actually incurred.

4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense for example: a Calendar Year maximum benefit, a lifetime maximum benefit, etc.

5. No payment, or a reduced payment, was made because some or all of the expenses for which the claim was filed were applied against a Deductible.

6. You or the person on whose behalf the claim was filed didn't submit the required subrogation documents which would permit the Plan to process the claim and recover payment from any other source.

7. Another Plan was primarily responsible for paying benefits for the expenses.

8. The Plan was terminated.

The preceding list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Plan Office.

Subrogation and Reimbursement

Plan's Right to Subrogation and Reimbursement

The Fund shall be entitled to subrogation or reimbursement with regard to all rights of recovery of an Eligible Employee or Eligible Retiree or for or on behalf of an Eligible Dependent, and said Employee, Retiree, or Dependent or representatives, guardians, beneficiaries, fiduciaries, Trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Employee, Retiree or Dependent (collectively, for purposes of this section, "Individual"), to extent of any amounts which the Fund has paid or may become obligated to pay on account of any claim against any person, organization or other entity in connection with the injury or bodily injury, sickness, accident, illness or condition, including accidental death or dismemberment, to which the recovery relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility and any Employer of the Individual under the provisions of a Workers' Compensation Act or Occupational Disease Law, as well as an individual policy of insurance maintained by the Individual which may also include uninsured, underinsured and/or umbrella insurance coverages.

The Fund shall also be entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by the Individual. Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses and regardless of whether liability is admitted to or contested by any Source. Once the Fund makes or is obligated to make payments on behalf of an Individual on account of the claim, the Fund is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Individual from any Source.

Action Required of Individual

If requested in writing by the Trustees, the Individual shall take, through any representatives designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Fund from any Source and shall hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Fund to be paid to the Fund immediately upon recovery thereof. The Individual shall not do anything to impair, release, discharge or prejudice the rights referred to in this section. The Individual shall assist and cooperate with representatives designated by the Fund to recover payments made by the Fund and shall do everything that may be necessary to enable the Fund to exercise its subrogation and reimbursement rights described herein.

The Trustees may also require the Individual to execute a Subrogation and Reimbursement Agreement ("Agreement"), in a form provided by and acceptable to the Trustees, as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s), at the Fund's request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may suspend all benefit payments. However, in its sole discretion, if the Fund advances claims in the absence of an Agreement, or if the Fund advances

claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person's parent, the Individual (in the case of a minor Dependent Child), the Individual's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Fund. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Individual agrees that out of any Source, as described above, the identified amount that the Fund has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Fund's benefit and that the Fund shall have an equitable lien by agreement which shall be enforceable if necessary under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Fund's subrogation and reimbursement rights shall apply regardless of whether the Individual executes an Agreement.

Any claim which is first received by the Fund after a recovery, regardless of when the claim is incurred, shall be the responsibility of the Individual to the extent of the Individual's net recovery and shall be paid by the Individual and not the Fund. In the event the Fund inadvertently provides benefits for such claim, the Individual shall have an obligation to repay the Fund to the extent of the Individual's net recovery. The Fund has the enforcement rights set forth below to recover such amounts.

Enforcement of Rights

The Fund has the right to recover amounts representing the Fund's subrogation and reimbursement interests under this section through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA section 502(a)(3), including injunctive action to ensure the claim amounts that the Fund has advanced are preserved and not disbursed, or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Fund's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual in the event an Individual.

Further, in the event an Individual receives monies as the result of an Injury or Bodily Injury, sickness, Accident, illness or condition and the Fund is entitled to such monies in accordance with this section and is not reimbursed the amount it has paid for such injury or bodily injury, sickness, accident, illness or condition, the Fund shall have the right to reduce future payments due to such Individual or the Eligible Employee of whom such Individual is a Dependent or any other Eligible Dependent of such Employee by the amount of benefits paid by the Fund until the Fund has recovered the full amount allowed under this section. The right of offset shall not, however, limit the rights of the Fund to recover such monies in any other manner described in this section.

Individual’s Attorney’s Fees

The Fund's subrogation and reimbursement rights apply to any recovery by the Individual without regard to legal fees and expenses of the Individual. The Individual shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury or bodily injury, sickness, accident, illness or condition, and the Fund's recovery shall not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Fund's claim by an agreed upon amount of such fees or expenses.

Disavowal of Common Law Defenses

The Fund specifically disavows any claims that an Individual may make under any federal or state common law defense, including but not limited to, the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Fund's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Individual from any Source without regard to legal fees and expenses of the Individual and the Individual will be solely responsible for paying all legal fees and expenses. The Fund shall have a priority, first-dollar security interest and a lien on any recovery received from any Source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or

described as payment for medical expenses or as amounts other than for medical expenses of such injury or bodily injury, sickness, accident, illness or condition.

Trustees' Right to Waive

The Trustees of the Fund may waive the above subrogation or reimbursement rights, or any part thereof, if they decide such action is in the best interest of the Fund and its participants, unless determined to be acting in an arbitrary and capricious manner.

Additional Plan Provisions

Payment of Benefits

Health care benefits are payable individually for you and each of your Dependents up to but not to exceed the maximum benefits described in the Benefit Components according to the following provisions:

1. All bills from Hospitals and Doctors who participate with BCBSM will automatically be sent to BCBSM, which pays the Plan's share of the expenses to the Hospital or Doctor. You will get an EOB from BCBSM telling you what BCBSM has paid. The Hospital or Doctor will bill you for the remaining amount of the bill not paid by BCBSM. You are responsible for paying this amount.

2. Doctors who do not participate with BCBSM and some other service providers may not agree to send their bills directly to BCBSM.

3. When you receive an EOB from BCBSM, please review it carefully.

4. All benefit payments for BCBSM PPO providers will be made directly to the providers.

5. If the Trustees decide that a person isn't mentally, physically, or otherwise capable of handling his business affairs, benefits may be paid to his guardian or to the individual who has assumed his primary care and maintenance, if there is no guardian. If the person dies before all due amounts have been paid, the Trustees may make payment to his estate, to his surviving spouse, parent, Child, or Children, or to any individual the Trustees believe is entitled to the benefits.

6. In determining the satisfaction of any Deductible amounts and the amount of benefit payments, a charge for any service, treatment, or supply will be considered to have been incurred on the date that it was provided to the patient.

7. Any payments made by the Plan in accordance with these provisions will fully discharge the Plan's liability to the extent of the payments. You are responsible for paying any Deductibles and Copayment percentages not paid by the Plan or BCBSM.

Release of Information

You must provide the Plan Office or BCBSM with any required verbal or written authorization for release of necessary information relating to any claim you have filed.

Examinations

The Trustees have the right to have a Doctor of their choice examine a person for whom benefits are being claimed, and to ask for an autopsy in the case of a death, provided an autopsy is not forbidden by law. They also have the right to examine any and all Hospital or medical records relating to a claim.

Free Choice of Doctor

You will have free choice of any Doctor who meets this Plan's definition of a Doctor. However, no reimbursement will be made for charges made by a Doctor beyond the coverage specifically provided under the Plan.

Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation Law, Occupational Diseases Law, or similar law. (Benefits which would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws).

Non-Guarantee of Employment

Nothing contained in this Plan shall be construed as a contract of employment between any Employer and any Employee, or as a right of any Employee to be continued in the employment of any Employer, or as a limitation of the right of any Employer to discharge any of its Employees, with or without cause.

Plan Discontinuation or Termination

The Trustees intend to continue the Plan. However, this Plan may be discontinued or terminated under certain circumstances—for example, if future Collective Bargaining Agreements and participation agreements do not require Employer contributions to the Plan. In such event, benefits for covered expenses incurred before the termination date established by the Trustees will be paid on behalf of eligible individuals as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement. However, any disposition of assets will be made only for the benefit of former Plan participants and for the purposes set forth in the Plan.

Right of Offset

If any payment is made by the Plan to or on behalf of a person who is not entitled to the payment or to the full or partial amount of such payment, the Plan has the right to suspend or withhold payment of incurred claims and to reduce current and/or future claim payments due to that person or his covered family members by the amount of any erroneous payment and by the amount incurred by the Plan pursuing the overpayment. The Plan and Trustees may take other actions to recover the erroneous payments and other amounts including, but not limited to, commencing an action under ERISA seeking restitution, imposition of a constructive trust or equitable lien, or other relief. The Plan will not withhold more than the amount of the erroneous payment and the amount incurred by the Plan in pursing collection of the overpayment. This right of off-set will not limit the right of the Plan to recover such erroneous payments in any other manner.

Legal Action

You may not file legal action against the Plan to recover loss until all of the proper claim and claim appeal procedures have been followed.

Falsified or Fraudulent Claims

All claims, enrollment forms and other information submitted or provided to the Plan, directly or indirectly, must be accurate and complete. If the Board of Trustees find at any time that false or inaccurate information has been submitted or provided to the Plan, directly or indirectly, in support of a claim, such claim will be denied and the Trustees can offset the amount improperly paid and/or terminate future coverage for the affected individual and his covered family members.

Rescission of Coverage

The Plan will not rescind health coverage under the Plan with respect to a Covered Individual (including a group to which the individual belongs or family coverage in which the individual is included), unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance has only a prospective effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is

attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. Retroactive elimination of coverage back to the date of termination of employment is not a rescission if due to a delay in administrative recordkeeping if the Employee does not pay any premiums for coverage after the termination of employment. A cancellation of discontinuance is not a rescission if the cancellation or discontinuation of coverage is effective to the date of divorce.

The Plan is required to provide at least 30 days advance written notice to each Covered Individual who is affected by a rescinding of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group.

Important Information About Your Plan

Name of Plan/Fund. The name of this Plan is the Michigan Electrical Employees' Health Plan.

Type of Plan. This multiemployer group health Plan is maintained for the purpose of providing medical, weekly disability, transitional disability, death, accidental death and dismemberment, and optional preventive dental, optional comprehensive dental and optional vision benefits.

Plan Sponsor and Plan Administrator. Your Plan is sponsored and administered by a joint-labor management Board of Trustees. The Board of Trustees consists of an equal number of Employer and Union representatives selected by Employers and the Unions that have entered into Collective Bargaining Agreements that relate to the Plan. You may write to the Plan Office to find out if an Employer or Union is a sponsor of the Plan, and, if so, to find out the Plan sponsor's address.

The Board of Trustees is the Plan Administrator. As of the effective date of this booklet, the Trustees of the Plan are:

Union Trustees

Aaron Pangborn
Local 665
5710 Ivan Drive
Lansing, MI 48917

David Fashbaugh
Local 498, IBEW
3912 Blair Townhall Road
West Traverse City, MI 49685

Evan Allardyce
Local Union #557, IBEW
7303 Gratiot Road
Saginaw, MI 48609

Jonas Talbott
Local 275
140 North 64th Avenue
Coopersville, MI 49404

Kurtis Monroe
Local Union 906
119 S Front Street
Marquette, MI 49855

Employer Trustees

Andy Mosser
Michigan Chapter, NECA
1026 North Washington Avenue
Lansing, MI 48906

Bryan Benton
Michigan Chapter
National Electrical Contractors Association
1026 N. Washington
Lansing, MI 48906

Chad Hunt
Hi-Tech Electric B & B Electric, Inc.
839 Lenox Drive 627 Circle Drive
Portage, MI 49801

Neil Parish
Michigan Chapter, NECA
1026 North Washington Avenue
Lansing, MI 48906

Alternate Union Trustees

Gregory Remington
Local 948, IBEW
1251 West Hill Road
Flint, MI 48507

Lance Dougherty
IBEW Local Union 445
1375 West Michigan Avenue
Battle Creek, WI 49037

Morris Applebey
IBEW Local Union 131
3641 East Cork Street
Kalamazoo, MI 49001

Ryan Charney
Local Union #692, IBEW
1300 West Thomas Street
Bay City, MI 48706

Alternate Employer Trustees

David Hoyt
Alpine Electric Corp.
1670 Barlow Street
Traverse City, MI 49685

Leah Anton
Newkirk Electric Associates, Inc.
1875 Roberts Street
Muskegon, MI 49442

Megan Doherty
Hayes Electric, FD
2301 Beal Avenue
Lansing, MI 48910

Trustee Address and Telephone Numbers. If you wish to contact the Board of Trustees, you may use the address and telephone numbers below:

Board of Trustees
Michigan Electrical Employees' Health Plan
c/o Wilson McShane Corporation
3001 Metro Drive Suite 500
Bloomington, MN 55425
Toll Free at (855) 633-4584 or (952) 854-0795

You can also contact the Trustees in writing by sending correspondence to:
Michigan Electrical Employees Health Plan Board of Trustees
c/o 1423 East Twelve Mile Road
Madison Heights, MI 48071

A complete list of the Employers and Employee organizations sponsoring the Plan may be examined at this address. A Plan Participant or beneficiary may obtain a copy of this list for a reasonable charge by writing to the Trustees at this address. In addition, upon written request to the Trustees at this address, a Plan Participant or beneficiary may obtain information as to whether a particular Employer or Employee organization is a sponsor including the sponsor's address.

Type of Administration. The Board of Trustees are assisted in the administration of the Plan by a third-party administrator (Administrative Manager), Wilson McShane Corporation, which is responsible for administration duties and some processing of claims and benefit payments. You may contact the Administrative Manager at the address and telephone number below. The Trustees are also assisted by BCBSM for most medical claim, and prescription drug processing and benefit payments, as well as Delta Dental for dental claims. The Trustees have divided certain functions into three areas of responsibility and have delegated them either to the Plan Office, Delta Dental or to BCBSM.

Service of Legal Process. The Plan's Administrative Office has been designated as the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal document should be served upon the Plan at the following address:

Administrative Manager
Michigan Electrical Employees' Health Plan
c/o Wilson McShane Corporation
3001 Metro Drive Suite 500
Bloomington, MN 55425

In addition, service of legal process may be made upon any member of the Board of Trustees listed above.

Source of Financing/Plan Participation. The Plan receives contributions from Employers under Collective Bargaining Agreements with the various Local Unions, from Employers that have special participation agreements with the Trustees, and from Employees, Retirees and Dependents who make self-payments. An Employee or Retiree can get a copy of a Collective Bargaining Agreement, or the agreement can be read at the Plan Office (see "How to Read or Get Plan Material" on page 148).

You are entitled to participate in this Plan if you work under one of the Collective Bargaining Agreements and if your Employer is required to make monthly contributions to the Plan on your behalf. Other persons entitled to participate in this Plan are certain Retirees, officers and Employees of the Unions, non-Bargaining Unit Employees of participating Employers, Employees of the Association, Employees of the Plan, and Employees of such other organizations as may participate in the Plan under the provisions of a participation agreement.

Accumulation of Assets/Payment of Benefits. Employer contributions and Employee, Retiree and Dependent self-payments are received and held in trust by the Trustees pending the payment of benefits and administrative expenses. The Plan is a multiemployer group health Plan and provides medical, prescription drug, dental and disability, and death and accidental death and dismemberment benefits on a self-funded basis. A Medicare Advantage Program is provided through Blue Cross Blue Shield of Michigan.

The self-funded benefits payable by the Plan are limited to Plan assets available for such purposes. This Benefit Plan is not an insurance policy and no benefits are provided by or through an insurance company.

Plan Year. The Plan's financial records are maintained on a 12-month fiscal year basis, beginning September of each year and ending on August 31 of the following year.

Plan Identification Numbers. The Employer Identification Number (EIN) assigned to the Plan by the Internal Revenue Service is 38-2106878. The Plan Number (PN) is 501.

Qualified Medical Child Support Orders (QMCSO). The Plan complies with all Qualified Medical Child Support Orders ("QMCSO"), including a National Medical Support Notice. QMCSO Procedures are available to you free of charge from the Plan Office upon request.

To write to the Board of Trustees or file a claim appeal, address your letter to the Board of Trustees, using the complete Plan name and address shown above. (See pages 126-135 for more information about filing an appeal.)

To write to the Plan Office, address your letter to: Administrative Manager, Michigan Electrical Employees' Health Plan, at the address shown above.

Local Unions Participating in this Plan
Kalamazoo Local Union No. 131
West Michigan Local Union No. 275
Battle Creek Local Union No. 445
Traverse City Local Union No. 498
Saginaw Local Union No. 557
Lansing Local Union No. 665
Bay City Local Union No. 692
Upper Peninsula Local Union 906
Flint Local Union No. 948

Reciprocity. The Plan is a participating trust fund in the Electrical Industry Health and Welfare Fund Reciprocal Agreement. If you need information about how to transfer hours worked, contact the Plan Office.

Collective Bargaining Agreements. This Plan is maintained pursuant to one or more Collective Bargaining Agreements. Plan Participants and beneficiaries may examine these Collective Bargaining Agreements at the Plan Administrative Office address listed above and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees.

Prohibition Against Assignment

Neither you nor your Dependents may, in any manner, anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge (collectively, for the purposes of this section, "assign") any right available due to coverage under the Plan, whether legal, equitable, or otherwise, including but not limited to any right to request documents or institute any court proceeding. In addition, neither you nor your Dependents may assign benefits payable under the Plan. Any such attempted assignment to another person or entity (such as a facility in which you or your Dependent are receiving or will receive care, a provider of medical services or supplies in consideration for medical services or supplies provided or to be provided, or any other person or entity that may have provided or paid for or agreed to provide or pay for any covered expense under the Plan (collectively, for the purposes of this section, a "provider")) will be null and void, and unenforceable. However, you may request that benefits due to you be paid directly to a provider. The Plan may treat any document attempting to assign your or your Dependent's rights or benefits to a provider as an authorization for direct payment by the Plan to the provider. In this case, or if the Plan otherwise deems it appropriate, the Plan may send payments for the claims to the provider, but will send all claim documentation, such as an explanation of benefits, and any procedures for appealing a claim denial directly to you or your authorized representative. The Plan may also make payments to you without regard to any actual or deemed authorization directing payment to a provider.

Your Rights and Protections Under ERISA

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

Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Office and at other specified locations, such as Union halls, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements and participation 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 Employee Benefits Security 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 Descriptions. The Plan 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 the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse or your 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 the 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 preexisting conditions under your group health Plan, if you have creditable coverage from another Plan. When you lose coverage under the Plan, you should be provided a certificate of creditable coverage. A certificate of creditable coverage will be provided whenever: (1) you lose coverage under the Plan and, therefore, become entitled to elect COBRA continuation coverage; (2) your COBRA continuation coverage ceases; (3) you request it before losing coverage; or (4) you request it up to 24 months after losing coverage. The certificate will be provided free of charge. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (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 the 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 benefit under the Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied, 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 rights listed above. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, you may file suit in Federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe 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. If you have any questions about your Plan, you should contact the Plan Office.

Assistance with your Questions

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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue New., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at **www.dol.gov/ebsa**.

How to Read or Get Plan Material

You can read the material listed in the previous section by making an appointment at the Plan Office during normal business hours. This same information can be made available for your examination at certain locations other than the Plan Office. The Plan Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Plan Office. There may be a small charge for copying some of the material. Before requesting material, call the Plan Office to find out the cost. If a charge is made, your check must be attached to your written request for the material.

Notice of Privacy Practices: Confidentiality of Protected Health Information

The Plan is required by law to maintain the privacy of your health information as described in the Plan's Notice of Privacy Practices. This Notice has been revised effective September 23, 2013 to reflect additional guidance on the limits on the use and disclosure of your protected health information, called PHI. This includes the use and disclosure of genetic information, psychiatric notes, and the sale or use of PHI for marketing purposes. The notice also clarifies that you will receive notice if a breach of your PHI occurs.

You can obtain a copy of the notice at any time (even if you have received a copy before) by going to the Plan's website, www.michiganelectrical.org, by contacting the Plan's Privacy Official at – Privacy Official, Michigan Electrical Employees' Health Plan, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, (855) 633-4584 or (952) 854-0795.

Notice of Nondiscrimination and Accessibility Services

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan provides the following services free of charge to qualifying individuals:

1. Aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
2. Language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Plan Office.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-321-7502.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-517-321-7502.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-517-321-7502。

ܙܘܗܪܐ: ܐܢ ܐܚܢܬܘܢ ܟܐ ܡܫܬܡܫܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܨܝܬܘܢ ܕܡܫܬܚܠܦܝܬܘܢ
ܒܚܕܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘ ܥܠ ܡܢܝܢܐ 1-517-321-7502

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-517-321-7502.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-517-321-7502.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-517-321-7502 번으로 전화해 주십시오.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-517-321-7502।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-517-321-7502.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-517-321-7502.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-517-321-7502.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-517-321-7502 まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-517-321-7502.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-517-321-7502.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-517-321-7502.

HIPAA PRIVACY AND SECURITY PROVISIONS

The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's Board of Trustees (the "Trustees"), as Plan Sponsor, for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

Disclosure of PHI to the Trustees

Disclosures by Plan. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

1. the Plan's Payment activities,

2. those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and

3. all of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

Uses and Disclosures of PHI by the Trustees. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

Privacy Safeguards. The Trustees agree to:

1. Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

2. Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

4. Not use or disclose PHI in connection with any other benefit or Employee benefit Plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

5. Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;

6. Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

8. Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

9. Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;

10. If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

11. Ensure that adequate separation between the Plan and the Trustees is established, as described below.

Adequate Separation. The Trustees may access and use PHI only for Plan administration functions. The Trustees may not use PHI for employment related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

Application of the Security Regulations. The Plan and the Trustees will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. Parts 160, 162, and 164 (the "Security Regulations"). The provisions in section 6 below apply to electronic PHI that is created, received, maintained, or transmitted by the Trustees on behalf of the Plan, except for electronic PHI: (a) the Trustees receive pursuant to an appropriate authorization (as described under 45 C.F.R. section 164.508); or (b) that qualifies as Summary Health Information and that the Trustees receive for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending, or terminating the Plan (as described under 45 C.F.R. section 164.504(f)(1)(ii)). The Security Regulations are incorporated herein by reference.

Security Safeguards. The Trustees agree to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that the Trustees create, receive, maintain, or transmit on behalf of the Plan;

2. Ensure that the "adequate separation" described above between the Plan and the Trustees, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. Ensure that any agent to whom the Trustees provide electronic PHI agrees to implement reasonable and appropriate security measures to protect electronic PHI; and

4. Report to the Plan any security incident of which the Trustees become aware regarding electronic PHI.

Hybrid Entity. For purposes of complying with the Privacy Regulations and Security Regulations, this Plan is a "hybrid entity" because it has both health Plan and non-health Plan functions. The Plan designates that its health Plan components that are covered by the Privacy Regulations and Security Regulations include only health Plan benefits and no other Plan functions or benefits.

Appendix A - Benefit Program Documents

The following Benefit Program Documents are incorporated into the Plan by reference. You will receive copies of the Benefit Program Documents applicable to your benefit:

1. BCBSM Community Blue PPO Benefits-at-a-glance
2. BCBSM Preferred RX Program Benefits-at-a-glance
3. BCBSM Medicare Plus Blue Group PPO
4. BCBSM Community Blue Benefits Certificate

Michigan Electrical Employees' Health Plan
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