Michigan Laborers Health Care Plan

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PIPELINE/ENERGY
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Summary Plan Description

February 2015
Section 1. Eligibility and Guidelines

Active Employees
Initial Eligibility Requirements
Continuation and Reinstatement of Eligibility
Employment Outside the Jurisdiction
Disability Hour Credit
Eligibility During Periods of Unemployment
COBRA Continuation Coverage
Qualified Medical Child Support Orders
A Word about Confidential Information
Health Insurance Portability and Accountability
Military Service Continuation Coverage
Self-Employed Laborers and Non-Bargaining Unit Employees
Total and Permanent Disability Self-Payment Programs
Schedule of Benefits for Totally and Permanently Disabled Participants
Early Retiree Self-Payment Program
Schedule of Benefits for Early Retiree Self-Payment Participants
Supplement to Medicare Program
Eligibility Provisions
Provisions for Continued Participation
Special Provisions
Schedule of Benefit for Participants Enrolled in the Supplement to Medicare Program
Retiree Self-Payment Program
Schedule of Benefits for Retiree Self-Payment Participants
Surviving Spouse Self-Payment Program
Active Employees and Their Spouses Who Are Age 65 or Older
Dependents
Disabled Dependents
Dependents Between Ages nineteen (19) and twenty-six (26)
Annual Certification
Eligibility Appeal
Call BCBSM ....................................................................................................................................................... 29
Visit BCBSM ...................................................................................................................................................... 29
Write BCBSM .................................................................................................................................................... 30
Claims information ........................................................................................................................................... 30
Filing a claim ............................................................................................................................................. 30 - 31
Your Explanation of Benefits (EOB) .................................................................................................................. 31
Online EOB statements .................................................................................................................................... 32
About your EOB ........................................................................................................................................ 32 - 33
Coordination of benefits (COB) ................................................................................................................ 34 - 36
Subrogation .............................................................................................................................................. 36 - 37
Appeals ............................................................................................................................................................. 37
Frequently asked questions and answers about your PPO plan .............................................................. 37 - 39
Glossary .................................................................................................................................................... 40 - 62

Section 3. Medical Benefits – Active Participants .................................................................................... 63 - 74
Schedule of Benefits for Active Participant Benefits ....................................................................................... 63
Preauthorization for Select Services ................................................................................................................ 63
Preauthorization for Specialty Pharmaceuticals .............................................................................................. 63
Eligibility Information ..................................................................................................................................... 63
Comprehensive Major Medical Blue Preferred - PPO .................................................................................... 64 - 69
Excluded Services ....................................................................................................................................... 70 - 72
No-Fault Auto Insurance ............................................................................................................................. 73

Section 4. Blue Preferred Rx .................................................................................................................. 75 - 78

Section 5. Dental Coverage .................................................................................................................... 79 - 82

Section 6. Blue Vision Coverage ............................................................................................................. 83 - 84

Section 7. Schedule of Benefits for Pre-Medicare Participant Benefits ...................................................... 85 - 96
Preauthorization for Select Services ................................................................................................................ 85
Preauthorization for Specialty Pharmaceuticals .............................................................................................. 85
Eligibility Information ..................................................................................................................................... 85
Comprehensive Major Medical ................................................................................................................... 86 - 92
Dental Benefits .......................................................................................................................................... 92
Vision Benefits .......................................................................................................................................... 92
Section 12. Other Important Information ................................................................. 119 - 120

Listing of Trustees ........................................................................................................... 119 - 120

Other Fund Contacts ...................................................................................................... 120
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Introduction

A Message from the Board of Trustees

Dear Participant,

This booklet describes the benefits available to you and your family through the Michigan Laborers’ Health Care Fund (Plan). In it, you’ll find information on eligibility for benefits, covered services, how to file a claim and your rights under the Plan, etc.

Read this booklet carefully. Use it for quick reference. As periodic changes are made in the Plan, we’ll provide you with written updates.

This booklet, called the “summary plan description” (SPD), summarizes the Plan’s key features. This booklet is also the Plan document.

Additional Plan details are also contained in the other official Plan documents, including the Plan’s Agreement and Declaration of Trust. Together, these Plan documents govern the Plan’s operation.

All Plan documents are available for your inspection at the Administrative Manager’s Office during normal business hours. All statements made in this booklet are subject to the provisions and terms of the complete Plan documents.

We’ve made every effort to make the Plan responsive to your needs. But, the ability to maintain a high level of benefits ultimately depends on you. By complying with the Plan rules and following the booklet instructions, you can help the Plan deliver the best benefits possible in the most efficient and cost-effective manner.

NO BENEFITS ARE GUARANTEED

No Plan benefit is guaranteed. We may modify or eliminate (without prior notice to you) any Plan benefits and/or change the Plan’s eligibility requirements.

We also have the sole authority and discretion to interpret all Plan documents, and all of the Plan benefits, and make final determinations regarding them.

If this booklet does not answer your specific questions, call the Administrative Manager’s Office at (877) 645-2267 Toll Free or (517) 321-7502.

Sincerely,

THE BOARD OF TRUSTEES
MICHIGAN LABORERS’ HEALTH CARE FUND
About the Plan

In 1973, your Union and the Employer Association created this Plan through collective bargaining. The Plan’s current sponsors are the Michigan Laborers’ District Council and The AGC of Michigan. The Plan provides health and related benefits to you and your family.

Although sponsored by your Union and Employer Associations, the Plan is not a Union or Employer subsidiary, agent or department. It is a completely independent organization. No Union dues are used to pay for benefits or operational expenses. The benefits are funded primarily by Employer contributions.

The Plan is a “jointly-trusteed” fund. That is, it is administered by a twelve (12) member joint Board of Trustees. This Board consists of six (6) Union-appointed Trustees and six (6) Employer-appointed Trustees. This Board establishes the Plan’s benefits, policies, rules and regulations related to the Plan’s operation. The Plan’s third-party administrator, TIC International, Inc., administers the Plan’s day-to-day operations.

The Board of Trustees and TIC are assisted by professional consultants and advisors who provide necessary expertise in their respective areas. These professionals include a Plan attorney, an investment consultant and investment managers, health benefit experts, auditors, actuaries and certified public accountants.

CAUTION

No one has the authority to speak for the Trustees on any matter related to the Plan except the full Board of Trustees or the Plan’s Administrative Manager to whom such authority has been delegated. The Administrative Manager’s decisions are subject to review by the Board of Trustees.

Internet Access

You may now access your fringe benefit fund information via the internet. The Michigan Laborers’ web site is located at www.michiganlaborers.org to view, print plan documents, forms and obtain other useful information.

In cooperation with TIC International Corporation, the Fund Administrator, you can also view your own personal account information via a secured network called the Benefit Inquiry Site. The Benefit Inquiry Site will allow you to verify that the funds have accurate personal information about you and your family. In addition, you can check the funds’ records for up-to-date information regarding employer contributions made in your behalf, Vacation Fund balances and your Pension history.

PROCEDURES FOR LOGIN TO INTERNET

To Login, simply proceed with the following instructions:

1. Connect to the Michigan Laborers’ Fringe Benefit Funds web site @ www.Michiganlaborers.org
2. Click on the Link that you want (Health Care, Pension, Vacation, Annuity or LECET)
3. Click on the Link “Current Benefit Status”. You will be redirected to the secured web site of TIC International Corporation

4. In the ID box, type your Social Security Number.

5. In the password box, type **NZ4M3H2** (This is a generic password that will only be used the first time you Login).

6. Click on the Login Button.

7. You will then be prompted to select a unique password and a secret question in case you lose your password. Example:

   - **First Name:** John
   - **Last Name:** Smith
   - **Middle Initial:** T
   - **Mother Maiden Name:** Jones
   - **New Password:** ______________ (6-12 characters total, must use alpha and numeric characters)
   - **Confirm New Password:** ______________
   - **Secret Question:** Who was my 1st grade teacher (You must choose a question to enter here.)
   - **Answer:** Michaelson (Answer to question you asked above)

8. After entering the above information, click the Sign Up Button and you will be taken back to the original login screen.

9. In the username box, type your **Social Security Number**.

10. In the password box type the **new password** you created.

11. Click on the Login Button and you will be taken to the Employee Menu.

You will now have access to the benefit information screens. On all subsequent logins please use the new password you created.

**Note:** In the event that you forget your password, click on the ‘forgot password’ link on the main sign on screen. You will then be prompted for your Name and SSN#. After clicking on the submit button your browser will return your secret question to you. Enter the answer exactly as you typed it in when you set up your password. Once again, click on submit, and if you have entered the correct response, your password will be displayed on the next screen.
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Section 1. Eligibility and Guidelines

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

This section describes eligibility for health care and prescription drug benefits, burial benefits and accidental death and dismemberment benefits.

Active Employees

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

Initial Eligibility Requirements

You will become initially eligible (i.e. eligible for the first time) on the first day of the second month following the month in which you are credited with at least seven hundred (700) hours of contributions made on your behalf for work performed within a six (6) consecutive month period. You will remain eligible for one (1) month.

For example, if you were credited with at least one hundred seventeen (117) hours in each of the six (6) consecutive months of January through June, you would be eligible for the month of August.

You do not have to satisfy the initial eligibility requirements if you have been eligible via employer contributions with the Laborers’ Metropolitan Detroit Health Care Fund within the latest sixty (60) month period and this Fund is now your Home Fund.

Continuation and Reinstatement of Eligibility

Once you have satisfied the initial eligibility provisions, you will continue to be eligible for three (3) consecutive months beginning with the second month following three (3) consecutive months for which contributions were received on your behalf for at least three hundred fifty (350) hours.

For example, if you have satisfied the initial eligibility provisions and have been credited with at least three hundred fifty (350) hours of contributions for the months of April, May and June, you will continue to be eligible for the months of August, September and October.

Once you satisfy the initial eligibility provisions, you could also continue to be eligible for the second month following the end of a twelve (12) consecutive month period during which contributions made on your behalf total at least one thousand, two hundred (1,200) hours for work actually performed.

You can earn a maximum of six (6) months of credited eligibility through a combination of the quarterly and the annual eligibility provisions.

However, you can continue to be eligible for one (1) additional month if you have at least one thousand, five hundred (1,500) hours of contributions remitted in your behalf during a twelve (12) month period.
If you lose your eligibility for a period of less than sixty (60) consecutive months, due to insufficient contributions made on your behalf, you will again be eligible on the first day of the second month following a period of three (3) consecutive months for which contributions of at least three hundred fifty (350) hours of work have been made by a contributing employer on your behalf.

For example, if you have not been eligible for a period of six (6) months and you return to work for a contributing employer and contributions are made on your behalf for work performed during the months of June, July and August that total at least three hundred fifty (350) hours, you would again be eligible on October 1, and would remain eligible for the months of October, November and December.

If you have not satisfied either of the reinstatement provisions described above and are not eligible by employer contributions or disability hours in what would have been the sixtieth (60th) consecutive month of ineligibility and you were not eligible under the Laborers’ Metropolitan Detroit Health Care Fund within the latest sixty (60) months, you must satisfy the initial eligibility provisions again unless you had at least seven hundred (700) hours of contributions made on your behalf by a contributing employer for work performed in the sixty (60) months immediately preceding the month you return to work and none of the seven hundred (700) hours are used toward eligibility.

**Employment Outside the Jurisdiction**

Frequently, Laborers accept employment outside the jurisdiction of their local union when there is no work available locally. The Plan has entered into reciprocity agreements with many other Funds covering Laborers that provide for the transfer of contributions back to this Fund. In most instances you must authorize the transfer of contributions in writing, although transfers between the Laborers’ Metropolitan Detroit Health Care Fund and this Fund are automatic in some circumstances. Transferred health care contributions that are different than the Fund’s currently hourly rate are pro-rated. This pro-rating of transferred contributions will affect your eligibility for Fund benefits.

For example, if you work one hundred (100) hours in another jurisdiction where the health care fund’s hourly contribution rate is five dollars ($5.00) – thirty cents (30¢) per hour less than the Fund’s current hourly rate. When these five dollars ($5.00) per hour health care contributions are transferred to this Fund, your credited hours will be reduced to reflect the lower hourly rate. Contact the Fund Office for more information.

**Disability Hour Credit**

If you are unable to work due to an injury or illness, you may be entitled to receive disability hour credit during the period of the time you are disabled. Disability credit will be given beginning with the date the participant becomes eligible. Disability hours will be credited toward eligibility at the rate of six (6) hours per workday, up to a maximum of one hundred twenty (120) hours per month for up to twenty-six (26) consecutive weeks. To apply for disability hours you must submit a *Loss of Time* form to the Fund Office, completed by both you and your physician, within one (1) year of the date the injury or illness begins.

Certification for the purposes of receiving Disability Hour Credit must be obtained from a physician who is an MD, DO or DPM (if disability is related to foot or ankle).
Eligibility During Periods of Unemployment

If you are an active employee and would otherwise lose your eligibility because you did not work enough hours, you may continue your eligibility through self-payments. When you become ineligible, the Fund Office will notify you of your self-payment rights. To qualify for self-payments, you must be ineligible because of a lack of available employment as a Laborer within the jurisdiction of the Fund or because, even though you are currently working as a Laborer for a contributing employer, you have not worked enough hours to remain eligible. (Work in the “jurisdiction of the Fund” means work under a collective bargaining agreement that requires Fund contribution to be made for you.) Your Local Union must verify your status each month. Employees who are temporarily disabled may also make self-payments to continue their coverage.

The amount of the self-payment is determined by the Board of Trustees and may be adjusted periodically. You should contact the Fund Office for current rates.

The maximum number of months of self-payments that can be remitted under the Plan is twenty-four (24) months.

COBRA Continuation Coverage

This section summarizes the rights and obligations of you and your eligible dependents under the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or “COBRA”. You, your spouse and your dependents (if any) should take time to read this section carefully.

You will want to understand the following definitions of these important terms to understand your COBRA rights.

Continuing Health Care Coverage Through COBRA

Coverage for you and your dependents ends upon loss of eligibility with the Michigan Laborers’ Health Care Fund. In most instances, coverage will terminate when you are not credited with sufficient contributions or you fail to make self-payments on a timely basis.

This section summarizes the rights and obligations of you and your eligible dependents under the Continuation Coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or “COBRA.” You, your spouse, and your dependents should take time to read this section carefully.

You will want to understand the definitions of these important terms to understand your COBRA rights.

Continuation Coverage – the coverage available to you and your family in the event you lose eligibility due to a Qualifying Event. If you elect Continuation Coverage, the Plan must provide coverage which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries for basic hospital, medical, and surgical benefits. Burial Benefits and Accidental Death and Dismemberment Benefits are not provided.
Qualified Beneficiary – an individual who is covered under the Plan on the day before a Qualifying Event, as well as a newborn child or child placed for adoption with you during the period of Continuation Coverage. Qualified Beneficiaries are you, your spouse or your dependent child(ren).

Qualifying Event – an event that causes you and/or your family to lose coverage under the Plan. The specific events which are Qualifying Events for you, your spouse and/or your children are explained in detail in the following sections. Depending on the Qualifying Event, Continuation Coverage is available for eighteen (18), twenty-nine (29) or thirty-six (36) months.

Employee Right to Elect Continuation Coverage

You, as a Qualified Beneficiary, have the right to choose Continuation Coverage if you lose eligibility for coverage under the Plan because not enough employer contributions are remitted to keep you eligible or your employment terminates for any reason except gross misconduct on your part. Either of those circumstances is what is known as a “Qualifying Event” for you, as an employee. These Qualifying Events entitle you and/or your family to elect eighteen (18) months of Continuation Coverage.

The Trustees, through the Fund Office, determine when a Qualifying Event occurs as a result of a reduction of employer contributions or a termination of employment based on information contained on submitted employer contribution forms. The Fund Office will determine when the COBRA Qualifying Event has occurred within one hundred twenty (120) days following receipt of the employer contribution form. The Fund Office will mail the COBRA election notice within sixty (60) days after it has determined that you or a qualified beneficiary has lost eligibility for coverage. You have sixty (60) days from the date you receive the election notice to elect to receive Continuation Coverage. If you do not elect coverage within sixty (60) days, you no longer have a right to receive Continuation Coverage.

If you qualify for Continuation Coverage under COBRA but do not elect such coverage for your entire family, your spouse and/or dependent children can still elect Continuation Coverage for themselves.

Continuation Coverage and “Self-Payments”

If you are an Active Employee and not disabled or retired and you choose to make self-payments to keep your eligibility because not enough employer contributions are made for you, you still have the right to elect continuation coverage. But, if you choose to make self-payments and stop making them for any reason, you can still elect continuation coverage. But, the number of months for which you could have made self-payments is subtracted from the period for which you can get Continuation Coverage. For example, if you would have lost eligibility because not enough employer contributions were made on your behalf and you made self-payments for four (4) months, the longest period for which you can elect Continuation Coverage is fourteen (14) months.

Your Spouse’s Right to Elect Continuation Coverage

Spouses of employees or Retired Participants covered under the Plan, as Qualified Beneficiaries, have the right to choose Continuation Coverage for themselves if they lose their group health care coverage under the Plan under any of the following circumstances:
• Termination of your employment (for reasons other than gross misconduct), or a reduction in
  the hours worked which results in your losing eligibility under the Fund;

• Your death or the death of a Retired Participant;

• Divorce or legal separation from you; or

• You become entitled to Medicare and are not eligible to continue coverage for your spouse
  under another portion of the Plan or choose not to continue such coverage.

These circumstances are known as Qualifying Events for your spouse. The first Qualifying Event entitles your
spouse to elect eighteen (18) months of Continuation Coverage. The other Qualifying Events would entitle your
spouse to elect thirty-six (36) months of Continuation Coverage.

Your Dependent Children’s Right to Elect Continuation Coverage

All of your dependent children covered under the Plan, as Qualified Beneficiaries, have the right to Continuation
Coverage if they lose their eligibility for coverage under the Plan under any of the following five circumstances:

• Termination of their parent’s employment (for reasons other than gross misconduct) or a
  reduction in the number of hours worked by their parent, who is the covered Employee under
  the Plan;

• Death of the parent, who is the covered employee under the Plan:

• Divorce or legal separation of their parents;

• You become entitled to Medicare and either are not eligible to continue coverage for the
  children or choose not to continue such coverage; or

• The child or children cease to satisfy the Plan’s definition of a “dependent child.”

These five circumstances are known as Qualifying Events for your dependent children. The first Qualifying Event
entitles your dependant child(ren) to elect eighteen (18) months of Continuation Coverage. The other Qualifying
Events entitle your dependent children to elect thirty-six (36) months of Continuation Coverage.

A newborn or adopted child will automatically be extended COBRA coverage if the parents already have COBRA
coverage. This may involve an increase in the COBRA premium charged. A newborn child or an adopted child
(or the child’s custodian or guardian) has a right; separate from his or her parents to elect Continuation
Coverage for eighteen (18) or thirty-six (36) months, depending on the Qualifying Event, even if the child’s
parent(s) do not elect Continuation Coverage.
Continuation Coverage for Disabled Persons

If you, your spouse, or any dependent child, as Qualified Beneficiaries, qualify for Social Security disability benefits at the time of a Qualifying Event then that Qualified Beneficiary can elect eighteen (18) months of Continuation Coverage. Or, at any time during the first sixty (60) days after you lose coverage due to a Qualifying Event you may purchase up to an additional eleven (11) months of Continuation Coverage (or a total of up to twenty-nine [29] months).

The disabled person and other family members who are not disabled may purchase this additional Continuation Coverage (subject to the applicable premium).

The Qualified Beneficiary must be determined eligible for Social Security disability benefits before the end of the eighteen (18) month Continuation Coverage period and must notify the Fund Office during the eighteen (18) month period and within sixty (60) days after the Social Security Administration awards Social Security benefits to the disabled person to obtain this additional coverage.

The Fund charges eligible disabled persons and their families a higher premium (up to one hundred fifty percent (150%) of the regular COBRA premium) for the up to additional eleven (11) months of Continuation Coverage. The higher premium applies to the disabled person and for other family members who elect to purchase additional COBRA coverage.

Eligibility for extended Continuation Coverage because of disability ends the first day of the month that is more than thirty (30) days after the date that the person is determined under the Social Security Administration to be no longer disabled. Federal law requires a disabled person to notify the Fund within thirty (30) days of a final Social Security Administration determination that they no longer are disabled.

Employee Obligations to Notify the Fund Office of a Qualifying Event

COBRA requires that you or a family member notify the Fund Office immediately about a divorce, legal separation, or a child losing dependent status under the Plan. If such an event is not reported to the Fund Office within sixty (60) days after it occurs, Continuation Coverage will not be permitted.

If you die, your surviving spouse (or dependent child) should contact the Fund Office immediately after your death. This assures that Continuation Coverage is offered to your surviving spouse and children at the earliest possible date.

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

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

The Fund Office may require you to provide information about your coverage under another group health care plan. The Fund may seek reimbursement directly from you if medical expenses are paid by the Michigan Laborers’ Health Care Fund through Blue Cross Blue Shield of Michigan because you or your dependents do not notify the Fund of other health care coverage.

**Second Qualifying Events**

The following rules concern second Qualifying Events. These rules only apply if the original Qualifying Event was termination of the employee’s employment (for reasons other than gross misconduct) or reduction in the number of hours worked by the employee. If you or your other Qualified Beneficiaries elect Continuation Coverage because of that Qualifying Event and a second Qualifying Event occurs during the coverage available as a result of the first Qualifying Event (or, twenty-nine [29] months if the eleven (11) month extension due to disability applies), then you (or they) may purchase additional Continuation Coverage, but total Continuation Coverage can never exceed thirty-six (36) months. An example of a second Qualifying Event would be:

- Death of the employee, if he or she is a covered employee under the Plan;
- Divorce or legal separation of the employee and his/her spouse;
- The employee, if a covered employee under the Plan, becomes enrolled in Medicare (Part A, Part B, or both); or
- For dependant children, the dependant child ceases to satisfy the Plan's definition of a "dependent child" (The rules for second qualifying events also apply to newborn or adopted children.)

The thirty-six (36) total months of Continuation Coverage available when a second Qualifying Event occurs includes the number of months you have already been covered under Continuation Coverage because the first Qualifying Event and months for which you made self-payments to stay eligible after the first Qualifying Event. The thirty-six (36) month total is not in addition to any months of Continuation Coverage and self-payment coverage that you have already had because of the first Qualifying Event. The Plan Administrator (Fund Office) must be notified within sixty (60) days of the second Qualifying Event or the additional extended coverage will not be allowed.

**Proof of Insurability is Not Needed to Elect Continuation Coverage**

You and your family members who are Qualified Beneficiaries do not have to show that you or they are insurable to purchase Continuation Coverage. But, you must make the required self-payment(s) for such coverage in accordance with specific due dates. The amount(s) and the due date(s) will be shown on the COBRA election notice.
Procedure for Obtaining Continuation Coverage

Once the Fund Office knows that a Qualifying Event has occurred which qualifies you or other family members who are Qualifying Beneficiaries for Continuation Coverage, the Fund Office will attempt to notify you or your family member of their rights to elect Continuation Coverage.

You will have sixty (60) days after the date on the election notice within which to notify the Fund Office whether or not you want the Continuation Coverage. If you do not elect the coverage within the sixty (60) day time period, your right to continue your group health care coverage will end.

Termination of Continuation Coverage

The law provides that Continuation Coverage may be cancelled by the Fund for any of the following reasons:

1. The Fund no longer provides group health care coverage to any Employees
2. The required self-payment for Continuation Coverage is not paid on time
3. The person remitting Continuation Coverage payments becomes covered under any group health care plan, after the Qualifying Event that does not include a pre-existing condition exclusion
4. The person remitting Continuation Coverage payments becomes entitled to Medicare.

Although your Continuation Coverage may be canceled as soon as you are covered by Medicare, a spouse or dependent child receiving Continuation Coverage at that time may continue purchasing such coverage for up to eighteen (18) or thirty-six (36) months minus any months of Continuation coverage received immediately prior to your coverage under Medicare. This option applies only if a spouse or dependent child is not also covered by Medicare.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

Receipt of Order

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

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

The procedures to determine whether medical child support orders are qualified medical child support orders shall follow the criteria established by Section 609 of the Employee Retirement Income Security Act of 1974, as amended and any applicable regulation and administration actions by agencies charged to enforce Section 609. Those criteria include:

1. Inclusion of the order in a judgment order or decree made pursuant to state domestic relations law or is made pursuant to state domestic relations law or made pursuant to a law relating to medical child support described in 42 U.S.C. 1396g issued by a court of competent jurisdiction or administrative process that has the force or effect of law in the state issuing the order.
2. Creation, assignment or recognition of the right of an alternate recipient to receive Fund benefits to which a participant or a beneficiary is entitled.
3. Whether the alternate recipient is a child of the Participant or a child adopted by or placed with adoption with a participant.
4. Inclusion of the name and last known mailing address of the affected participant and the name and last known mailing address of the alternate recipient.
5. Inclusion of a description of the type of coverage to be provided by the Fund or the manner in which such coverage is to be determined.
6. Identification of the period for which the order applies.
7. Identification of the Fund as the plan to which the order supplies.
8. Verification that the order does not require the Fund to provide benefits or a form of benefits other than one provided by the Fund, provided that the Fund shall satisfy requirements of applicable laws relating to medical child support described in 42 U.S.C. 1908.

Effect of National Medical Support Notices

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

Status of Alternate Recipients

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

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

Notification Issues

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

A Word about Confidential Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Fund, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (PHI). Broadly speaking, PHI includes demographic information about you and/or your dependents, such as your name, address, telephone number and Identification Number, in conjunction with information concerning you and/or your dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations.

The Plan's use and disclosures of PHI is explained in detail in the Privacy Notice previously mailed to you. If you would like another copy of this notice, please contact the Fund Office.

The Plan and the Trustees are committed to observing these privacy rules and ensuring the confidentiality of your PHI. Your cooperation and understanding in working with the Plan to achieve compliance with these federal requirements is appreciated.

Health Insurance Portability and Accountability

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

**Military Service Continuation Coverage**

You are entitled to continue your Fund health care coverage for up to twenty-four (24) months if you stop working in covered employment to enter the “uniformed services.” You are considered to be in the uniformed services when you are in the Armed Forces or in active duty for training, inactive duty for training, or full time duty in the National Guard, the Air National Guard, or the commissioned corps of the Public Health Service. When an eligible active participant is called to active duty, this eligibility under the Fund is frozen and is reinstated upon his return to employment with an employer who is contributing to the Fund; provided he contacts the Fund Office within thirty (30) days of his return.

For example, if at the time you are called to active duty, you have four (4) months of eligibility remaining, you can “freeze” those four (4) months to be available for your future use once you return to work for an employer obligated to contribute to the Fund on your behalf.

You may be required to pay a monthly fee to continue coverage. To assure that this coverage is provided on a timely basis, please notify the Fund Office immediately upon entry into the uniformed services. You should contact the Fund Office for more details.

**Self-Employed Laborers and Non-Bargaining Unit Employees**

Self-employed Laborers and non-bargaining unit employees who have signed an appropriate agreement or whose employer has signed an appropriate agreement may participate in the Plan, and maintain coverage, by making contributions. Contact the Association Benefits Company at 800-782-0712 for details.

**Total and Permanent Disability Self-Payment Program**

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

1. The State of Michigan Laborers’ District Council Pension Fund; or
2. The Laborers’ Pension Trust Fund - Detroit & Vicinity; or
3. The Social Security Administration; or
4. The Laborers’ International Pension Fund.

If you are not receiving a monthly pension benefit from one of the above sources, you may be eligible to participate in this self-payment program if you have been eligible by employer contributions in at least five (5) of the ten (10) years immediately preceding the date your disability begins.
You must be eligible by either employer contributions, disability hours or self-payments on the date you apply for coverage to be eligible to participate in the Total and Permanent Disability Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

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

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union unless otherwise waived for a non-bargaining unit employee covered under a signatory employer’s participation agreement;
3. You become eligible for Medicare;
4. Termination or modification of the Total and Permanent Disability Self-Payment Program;
5. Your dependents no longer meet the definition of eligible dependent under the Plan;
6. Death of the totally and permanently disabled participant.

Participants with at least fifteen (15) years in the Laborers’ Pension Fund who for extraordinary reasons do not remit self-payments until they receive a Social Security Disability Award and/or Pension Benefits, may file an appeal for reinstatement in the Plan.

**Schedule of Benefits for Totally and Permanently Disabled Participants**

The schedule of benefits for Totally and Permanently Disabled Participants and their dependents (who are not eligible for Medicare) is the same as the schedule of benefits in effect for the Active (Non-Retired) Participants except that Totally and Permanently Disabled Participants and their dependents are not eligible for Disability Hour Credit, and Accidental Death and Dismemberment Benefits and the Totally and Permanently Disabled Participant must remit an additional monthly self-payment to be eligible for dental benefits. Dental Benefit coverage must be elected at the time of the first self-payment as a Totally and Permanently Disabled Participant.

The schedule of benefits for dependents of Totally and Permanently Disabled Participants who are eligible for Medicare is described in Section Eight (8).

**Early Retiree Self-Payment Program**

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

1. The Michigan Laborers’ Pension Fund; or
2. The Laborers’ Pension Trust Fund - Detroit & Vicinity; or
3. The Social Security Administration; or
4. The Laborers’ International Pension Fund.
You must be eligible by either employer contributions or active self-payments on the date of retirement to be eligible to participate in the Early Retiree Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

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

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union unless otherwise waived for a non-bargaining unit employee covered under a signatory employer’s participation agreement;
3. You become eligible for Medicare;
4. Termination or modification of the Early Retiree Self-Payment Program;
5. Your dependents no longer meet the definition of eligible dependent under the Plan;
6. Death of the early retiree.

**Schedule of Benefits for Early Retiree Self-Payment Participants**

The schedule of benefits for Early Retiree Participants and their dependents (who are not eligible for Medicare) is the same as the schedule of benefits in effect for the Active (Non-Retired) Participants except that Early Retiree Participants and their dependents are not eligible for Disability Hour Credit, Accidental Death and Dismemberment Benefits; and the Early Retiree must remit an additional monthly self-payment to be eligible for dental benefits. Dental Benefit coverage must be elected at the time of the first self-payment as an Early Retiree Participant.

The schedule of benefits for dependents of Early Retiree Participants who are eligible for Medicare is described in Section Seven (7).

**Supplement to Medicare Program**

**Eligibility Provisions**

This coverage is available to those retired participants and/or spouses who are sixty-five (65) and/or eligible for Medicare. Widows eligible for Medicare may also be eligible for this coverage. Coverage is provided through Self-Payments under the Supplement to Medicare Program. To participate in this Program, a Retired Participant must:

1. Be eligible by employer contributions or self-payments at the time of application for the Supplement to Medicare;
2. Have been eligible (by hours) in at least ten (10) of the last fifteen (15) years immediately preceding the date of retirement with at least four hundred eighty (480) hours of health care contributions remitted in each of the ten (10) fiscal years;
3. Have both Parts A (Hospital) and B (Medical) coverage under Medicare. (A copy of the Retiree and/or Spouse’s Medicare Card must be submitted);
You are required to enroll in both parts A and B of Medicare when you become eligible for Medicare. You should immediately forward a copy of your Medicare Card to the Fund Office. You are not required to enroll in the Medicare Part D Prescription Drug program.

4. Be a member in good standing with his Local Union;
5. Have lost their coverage based on employer contributions;
6. Must be receiving a monthly pension benefit from Michigan Laborers’ Pension Fund unless otherwise waived for a non-bargaining unit employee covered under a signatory employer’s participation agreement;

The Retiree and/or his spouse are eligible to be added on the first day of the month following the month he/she becomes eligible for both Parts A & B of Medicare.

A Spouse or widow is eligible to be added to this program only if the Retiree meets provision numbers (1), (2), (3), (4), and (5) as shown above. In addition, the Retired Participant must be maintaining coverage for himself under one of the Retired Participant Self-Payment Programs.

**Because the current prescription drug benefit offered to you through the Michigan Laborers’ Health Care Fund is as good as or better than that available under a Medicare prescription drug plan, the Trustees have decided to continue the current prescription drug coverage for retirees.** It is therefore imperative that you do not enroll in the Medicare Part D Prescription Drug Program. **If you do enroll in the Medicare Part D prescription drug coverage, your coverage through the Fund will be terminated.**

**Provisions for Continued Participation**

The Retired Participant may continue his coverage under the Supplement to Medicare Program until one of the following occurs:

1. Failure to remain a member in good-standing with his Local Union.
2. Termination or modification of the Supplement to Medicare Program.
3. Death of the Retired Participant.
4. Retired Participant loses his Medicare coverage.

The Retired Participant may continue coverage for his spouse and/or eligible dependent children under this Program until one of the following events occurs:

1. Failure to remain a member in good-standing with his Local Union.
2. Dependent no longer qualifies for Medicare.
3. Children no longer meet the definition of Dependent Child.
4. The Spouse no longer meets the definition of Spouse.
5. Termination or modification of the Supplement to Medicare Program.

The widow of a Retired Participant may continue coverage under this Program until one of the following events occurs:

1. Dependent no longer qualified for Medicare.
2. Termination or modification of the Supplement to Medicare Program.
3. Remarries

**Special Provisions**

If the Retired Participant is single and remitting self-payments, and then marries, he may begin to cover his new spouse effective with the date of marriage, provided that proof of his marriage is submitted to the Fund Office within thirty (30) days from the date of such marriage along with the additional self-payment. The current rates can be obtained from the Fund Office.

**Schedule of Benefit for Participants Enrolled in the Supplement to Medicare Program**

Supplement to Medicare coverage works with Medicare to extend your health care benefits and provides the same benefits as the active participants receive. Services are paid as follows:

Medicare deductibles and copayments are covered at eighty percent (80%) and you pay twenty percent (20%). Once your copayment maximum of one thousand, two hundred dollars ($1,200) has been reached for the calendar year, your Plan will pay one hundred percent (100%) of approved services for that year.

Listed below is a brief summary of your Supplement to Medicare coverage:

- The Medicare deductibles are covered at eighty percent (80%)
- Medicare co-payments are covered at eighty percent (80%)

**Retiree Self-Payment Program**

This program provides coverage for the eligible dependents of retired participants who are eligible for Medicare and are no longer covered under the Plan. Your dependents will be eligible for coverage under the Retiree Self-Payment Program if you are receiving monthly pension benefits from one of the following sources:

1. The State of Michigan Laborers’ District Council Pension Fund; or
2. The Laborers’ Pension Trust Fund - Detroit & Vicinity; or
3. The Social Security Administration.

You must be eligible by either employer contributions, disability hours, or active self-payments on the date of retirement to be eligible to participate in the Retiree Self-Payment Program. Coverage under this program must
You may continue coverage under the Retiree Self-Payment Program until one of the following occurs:

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

**Schedule of Benefits for Retiree Self-Payment Participants**

The schedule of benefits for the dependents of Retired Participants (who are not eligible for Medicare) is the same as the schedule of benefits in effect for the Active (Non-Retired) Participants except that dependents of Retired Participants are not eligible for Disability Hour Credit, Death Benefits, Accidental Death and Dismemberment Benefits and the Retiree’s dependents must remit an additional monthly self-payment to be eligible for dental benefits. Dental Benefit coverage must be elected at the time of the first self-payment as a dependent of a Retired Participant.

**Surviving Spouse Self-Payment Program**

This program provides coverage for the eligible dependents of deceased Participants who are not eligible for Medicare. Your dependents will be eligible for coverage under the Surviving Spouse Self-Payment Program if you were entitled to receive monthly pension benefits from the State of Michigan Laborers’ District Council Pension Fund.

You must be eligible by either, employer contributions, disability hours or self-payments on the date of death in order for your dependents to be eligible to participate in the Surviving Spouse Self-Payment Program. Coverage under this program must begin immediately upon the death of the participant and/or after the Participant’s eligibility via employer contributions has been exhausted.

Your dependents may continue coverage under the Surviving Spouse Self-Payment Program until one of the following occurs:

1. Your dependents fail to make their self-payment on time or in the proper amount;
2. Your dependents become eligible for Medicare;
3. Termination or modification of the Surviving Spouse Self-Payment Program;
4. Your dependents no longer meet the definition of eligible dependent under the Plan.

All self-payments are due in the Fund Office on the first day of the month for which payment is being made. Self-payments should be made by check or money order, made payable to “Michigan Laborers’ Health Care Fund.”
Fund.” Coverage through the Self-Payment Program must be continuous. Anyone eligible to participate in the Self-Payment Program but who fails to make a self-payment within the allotted time and in the proper amount for a month will not be reinstated at any time in the future.

Once the Surviving Spouse remarries, he/she is no longer eligible to participate in the Surviving Spouse Self-Payment Program.

Active Employees and Their Spouses Who Are Age 65 or Older

If you continue to work beyond the date you or your spouse reaches age sixty-five (65), you have the option of making either the Fund or Medicare your primary payor of benefits. The Fund will automatically be the primary payor unless you elect to have Medicare become the primary payor. If you elect to have Medicare become the primary payor you are not eligible to have supplemental benefits. Such an election must be in writing and filed with the Fund Office. Contact the Fund Office for more information.

Dependents

Eligible Dependents include your spouse, any legally separated spouses and any unmarried children until the end of the calendar year in which they age to twenty-six (26). These can include:

- Your children by birth, legal adoption, or legal guardianship while in your custody and dependent on you.
  
  Note: An adopted child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

- Children of your spouse while they are in the custody of and legally dependent on your spouse and reside as members of your household.

- Children who do not reside with you but are your legal responsibility for the provision of medical care (e.g., children of divorce parents).

Disabled Dependents

Disabled dependents may be covered if they are totally and permanently disabled prior to the end of the calendar year that ends before they reach age twenty-six (26) and you notify the Fund Office of the condition in writing. The disability must be from a medically determined mental or physical condition that prevents them from being self-supporting. They must be unmarried and dependent on you for support and care. You will be required to show verification of a dependent’s total and permanent disability. Disabled dependents may remain covered to any age.
Dependents Between Ages nineteen (19) and twenty-six (26)

Effective September 1, 2011 dependents who are between nineteen (19) and twenty-six (26) may continue coverage under your contract if they are not eligible to enroll in an employer-sponsored health plan maintained by the dependent’s employer or spouse’s employer. This is according to the Patient Protection and Affordable Care Act of 2010 Extension of Coverage to Adult Children until age twenty-six (26). Dependents are covered until the end of the month that they turn twenty-six (26).

Annual Certification

Each year, you must certify to the Fund that all of the children who you claim as dependents meet these requirements.

Eligibility Appeal

If you are denied eligibility for any reason, the participant will be notified in writing and given the opportunity for a review of his eligibility by the Board of Trustees.

The written denial will give (a) specific reason(s) for the denial, (b) a reference to the specific Plan Provision(s) on which the denial is based, (c) an explanation of the Fund's Appeal Process. Review Procedure within sixty (60) days after the participant receives written notice that his eligibility has been denied, the participant or his representative may make a written request for review to:

MICHIGAN LABORERS’ HEALTH CARE FUND
ATTN: APPEALS COMMITTEE
6525 Centurion Drive
Lansing, MI 48917
TOLL FREE # 1-877-645-2267
Telephone # 517-321-7502
FAX# 517-321-7508

Be sure to include your Member Identification Number and Local Union Number on all correspondence.

The participant may review pertinent documents relating to the denial and he may submit issues and comments in writing

1. Decision on Review:

A decision by the Board of Trustees will be made promptly and not later than ninety (90) days after receipt of the participant’s request for review. The decision of the review will be in writing and will include specific reasons for the decision.
Section 2. BCBSM Benefits Guide

Welcome

Blue Cross Blue Shield of Michigan (BCBSM) has provided this section that explains your health care coverage. When you are well informed about your coverage and your health care benefits, you will have the confidence and security that come from knowing health care coverage is available when you need it.

Please take time to read this benefit guide and familiarize yourself with your health care coverage. By reading each section carefully, you will understand your benefits and know how to use them wisely. You will also be informed of any out-of-pocket costs that are your responsibility.

For a complete description of your health care coverage, refer to your certificates, riders and plan modifications, as applicable. These documents are available online.

To view your certificates, riders, and plan modifications go to bcbsm.com and log in to Member Secured Services. If you are a first time user, you must register.

Members without online access may contact BCBSM Customer Service to obtain copies of their certificates and riders or your Fund Office for other plan documents. See the Customer service section for information on contacting BCBSM.

If you come across a health care term you don’t understand, look in the Glossary section of this benefit guide or refer to your certificates, riders and plan modifications. The Glossary provides the definitions of many terms you may be unfamiliar with.

Questions

If you have questions about your health care coverage, you may call, visit or write BCBSM. You may also reference the back of your BCBSM ID card for customer service phone numbers. See the Customer service section of this benefit guide for information on contacting BCBSM.

The information contained herein provides a summary of your group’s health care benefits. It is not a contract. This summary may not reflect all limitations and exclusions that apply to your health care plan or the most recent updates to BCBSM certificates, riders, plan modifications and/or changes that your Plan may be making to your health care benefits. If you have questions about your health care benefits, please contact your Fund Office or call the BCBSM Customer Service phone number on the back of your BCBSM ID card.

How your plan works

The following are general guidelines about your PPO health care plan. Please refer to your certificates, riders, plan modifications and other plan documents for detailed information, including limitations and exclusions.
**Referrals**

You can self-refer to any PPO provider and remain in-network. However, referrals to non-network providers must be coordinated by your PPO provider to remain payable at the in-network level of benefits. You must obtain the referral before receiving the referred services or the service will be subject to applicable out-of-network deductible and copay requirements.

It is important to remember that a referral does not guarantee payment. To be covered, the referred service must be a covered benefit under your health care plan.

**Note:** While the out-of-network deductible and copay requirements may not be imposed, covered services will be subject to applicable in-network deductible (if any) and copay requirements.

If you are referred to a non-network, nonparticipating provider, you are responsible for any difference between the provider’s charge and the BCBSM-approved amount.

**Limited network**

For certain providers (e.g., certified registered nurse anesthetists and independent licensed physical therapists), BCBSM does not have a PPO network. If you receive services from a provider for which there is no PPO network, covered services will be covered at the in-network level of benefits. If you are unsure whether or not there is a PPO network for a service, please contact BCBSM Customer Service.

**Note:** Providers who are NOT in the BCBSM PPO network are called non-network providers. When you receive medical services from a non-network provider, without a written referral from a PPO network provider, the BCBSM payment is still based on the BCBSM-approved amount.

- Providers who participate in the BCBSM Traditional program are called Blues participating providers. Blues participating providers, although not in the PPO network, will accept the BCBSM-approved amount, less applicable out-of-network deductible and copays, as payment in full for covered services.
- Providers who have NOT signed a participation agreement with BCBSM are called nonparticipating providers. Because nonparticipating providers often charge more than the BCBSM-approved amount, the BCBSM payment may be less than the amount charged by the provider. You are responsible for any differences between the nonparticipating provider’s charge and the BCBSM-approved amount (called balance billing). This difference is in addition to the out-of-network applicable deductibles and copays required by your health care plan.
Emergency care

When you think emergency care is needed, go to the nearest medical facility. Services for the initial exam to treat a life-threatening medical emergency or an accidental injury are covered at the in-network level of benefits when the diagnosis meets medical emergency guidelines. However, any needed follow up care is not considered emergency care and is subject to the guidelines of your health care plan.

Experimental services

Blue Cross Blue Shield of Michigan does not pay for experimental services. Facility services and physician services, including diagnostic tests related to experimental procedures are also not payable. Please refer to your certificate(s) for an explanation on how BCBSM determines experimental services.

Pain management

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

Healthcaring programs

Getting or staying healthy, or learning how to manage a chronic illness, takes a partner – a healthcaring partner – and that is Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan personal support programs help you understand the advice and treatment you receive from your physician to help you make the best and most-informed health care choices.

All programs are voluntary and strictly confidential.

Healthcare Advisor™

Healthcare Advisor is an online resource that helps you:

- Research and compare drug treatment options, how they are used to treat a condition, and if there are possible interactions with other medications you may be taking
- Select a physician using criteria that are most important to you – including specialty, years of experience and location
- Find and compare hospitals using factors most important to you
- Estimate costs for specific services or tests
BlueHealthConnection®

Whether you are looking for ways to improve your lifestyle or manage a chronic illness such as asthma or high blood pressure, BlueHealthConnection has the support system you need – and it starts with a phone call to BlueHealthConnection at 1-800-775-BLUE (2583).

Here are some BlueHealthConnection resources to help you get healthier, stay healthy or manage illness:

- **Health assessment** – An online questionnaire helps you pinpoint specific health issues and risks, and guides you to healthy behaviors.
- **Digital health coaching** – A team of virtual experts provides you with a personalized plan and supportive tips on how to embrace a healthier lifestyle.
- **Chronic condition management** – Experienced, licensed registered nurses help you learn how to self-manage your chronic condition with a number of support resources and services.
- **Case management** – Experienced, licensed registered nurse case managers help coordinate your care and provide information to help you deal with your chronic condition.
- **Adding extra value** – Useful online resources, discounts and special offers add unmatched worth to your health plan.

BlueHealthConnection offers a variety of state-of-the-art online health and wellness resources. You can:

- Research topics specific to men, women, children and mature adults
- Use calculators to determine healthy weight, calorie burn rate, target heart rate and much more
- Quiz yourself about acne, addiction, diseases, food, drugs, vitamins and other health-related issues
- Watch videos, listen to podcasts and use other interactive multimedia tools to learn about various health topics

BlueHealthConnection also offers savings and special offers on health products and services.

If you have questions and want more information on BlueHealthConnection, call 1-800-775-BLUE (2583) or go to bcbsm.com and log in to Member Secured Services.

Money-saving programs

Show your BCBSM ID card to save money through the following programs.

**BlueSafe℠**

This is an injury prevention program that provides you with exclusive discounts on safety products and equipment at various Michigan retailers.
Naturally Blue℠

Show your BCBSM ID card to receive a 20 percent discount on acupuncture, massage therapy and nutrition counseling from Naturally Blue network practitioners. You can also get discounts on vitamins and herbal supplements.

Weight Watchers®

Blues members are eligible for discounts at Florine Mark Weight Watchers locations in northern and southeast Michigan. Take advantage of the Blues’ discount at Weight Watchers for a new, healthier you! Your Weight Watchers savings depend on your branch location. Visit bcbsm.com to find the discount information for your county.

**Note:** For more information on these programs, visit bcbsm.com.

Your BCBSM ID card

This section provides information on using your BCBSM ID card.

**Your Identification card**

Once you are enrolled for health care-coverage, you will receive a BCBSM ID card similar to the one below. All cards will show the participant’s name.

**Contract number:** The participant’s assigned identification number with BCBSM.

**Plan code:** Identifies you as a Michigan BCBS member to out-of-state providers.

**Enrollee name:** The participant’s name as it appears on BCBSM membership records.

**Group number:** A unique group identification number that identifies the sponsors of the health care plan.

**About your ID card**

- Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.
- Unless you request a replacement card, you will receive new ID cards only when there is a change in your benefit plan.
Call your Fund Office if your card is lost or stolen. Your provider can call BCBSM to verify your coverage until you receive your new card.

If you need additional ID cards, you can request new cards at no cost. Go to bcbsm.com and log in to Member Secured Services or call your Fund Office or the BCBSM Customer Service phone number on the back of your ID card.

Preventing fraud

If your provider asks for another form of identification, do not worry. Checking a cardholder’s identification is one way providers help protect you against unauthorized use of your ID card.

You can help prevent fraud by reporting a lost or stolen ID card and by checking your Explanation of Benefit Payments statements, or EOB. If you see a discrepancy on your EOB, contact your provider first to see if it is an error. If it is not and you believe it is a fraudulent billing or use of your card, then let BCBSM know.

There are three ways you can report suspected fraud:

1. Visit the BCBSM Web site at bcbsm.com
2. Write or fax BCBSM
   You can download the form on the BCBSM Web site, fill it out online, print it and mail or fax it to BCBSM. The address and fax number are printed on the form.
3. Call the BCBSM Antifraud Hotline at 1-800-482-3787
   The hotline is open Monday through Friday from 8:30 a.m. to 4:30 p.m.

All fraud reports are confidential, and you remain anonymous.

Choosing your provider

How much you pay for services you receive depends on whether you use a PPO network or non-network provider.

What is a network provider?

A network provider is a physician, hospital or other licensed facility or health care professional who provides services through the BCBSM PPO network. PPO network providers have a signed participation agreement with BCBSM to accept the BCBSM-approved amount as payment in full for services covered under your health care plan. Using PPO network providers limits your out-of-pocket costs for covered services to any in-network deductible and copays (percent and fixed dollar copays) that may be required by your health care plan.

Special note to parents of students: Dependents attending school away from home still need to choose a PPO network physician to remain in-network. See the BlueCard program section of this guide.
What is a non-network provider?

A non-network provider is a physician, hospital or other licensed facility or health care professional who has not signed a participation agreement with BCBSM to provide services through the BCBSM PPO network. You are generally required to pay higher deductibles and copays for covered services received outside the PPO network.

**Important:** Outside the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept the BCBSM-approved amount plus your out-of-network deductible and copays as payment in full for covered services. Nonparticipating providers have not signed a participation agreement with BCBSM. They can bill you for any differences between their charges and the BCBSM-approved amount (called balance billing).

Comparing out-of-pocket costs between PPO network and non-network providers

Here is a comparison of out-of-pocket costs you may incur when you use a PPO network provider-and a non-network provider.

<table>
<thead>
<tr>
<th>When you choose a PPO network provider</th>
<th>When you choose a non-network provider who is a Blues Traditional participating provider</th>
<th>When you choose a non-network provider who is a nonparticipating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay <strong>lower</strong> out-of-pocket costs* through:</td>
<td>You pay <strong>higher</strong> out-of-pocket costs through:</td>
<td>You pay the <strong>highest</strong> out-of-pocket costs through:</td>
</tr>
<tr>
<td>• Fixed dollar copays for selected office visits and hospital emergency room services</td>
<td>• Fixed dollar copay for hospital emergency room services</td>
<td>• Fixed dollar copay for hospital emergency room services</td>
</tr>
<tr>
<td>• Percent copay for private duty nursing, and if applicable, other select services</td>
<td>• Percent copay for most covered services</td>
<td>• Percent copay for most covered services</td>
</tr>
</tbody>
</table>

* Your health care plan may also require you to pay in-network deductibles and percent copays. Please refer to the Benefit Chart for your specific health care plan requirements (i.e., cost-sharing amounts).

How providers are paid

The payment allowed for covered services is called the BCBSM-approved amount. The BCBSM-approved amount is the lower of the provider’s billed charge or the BCBSM-maximum payment level for the covered service. Any deductibles and/or copays required by your health care plan are subtracted from the approved amount before BCBSM makes its payment.
PPO network providers – BCBSM sends payment directly to network providers. Because of their signed participation agreement with BCBSM, network providers will accept the BCBSM-approved amount as payment in full for covered services. You are only responsible for any in-network deductible and/or copays that may be required by your health care plan.

Non-network providers – Unless you have a referral from a PPO network provider, your care is considered out-of-network. When choosing to receive services out-of-network, it is important to verify if the service is covered, because some services are not covered out-of-network.

When using non-network providers, you need to find out if the provider is participating or nonparticipating with BCBSM. Here’s why this is important:

- **Non-network, participating providers** – BCBSM sends payment directly to participating providers. Because they have a signed agreement with BCBSM, participating providers will accept the BCBSM-approved amount as payment in full for covered services. You are only responsible for out-of-network deductibles and copays required by your health care plan.

- **Non-network, nonparticipating physicians and other professional providers** – BCBSM sends payment directly to you, and it is your responsibility to pay the provider. Because the BCBSM-payment issued to you may be less than the provider’s charge, you may have to pay the provider any differences between the provider’s charge and the BCBSM payment. This difference is in addition to the out-of-network deductibles and copays required by your health care plan.

- **Non-network, nonparticipating hospitals, facilities, and alternatives to hospital care providers** – BCBSM’s payment for services received at nonparticipating hospitals is very limited and covers only those services required to treat accidental injuries or medical emergencies. This means you will need to pay most of the charges yourself and your bill could be substantial. Please refer to your certificates, riders and other plan documents for a complete explanation of your coverage when services are provided by a nonparticipating hospital or facility.

BlueCard® program

BlueCard is a national program that enables members of one Blue company to obtain healthcare services while traveling or living in another Blue company’s service area. The program links participating healthcare providers with the independent Blue companies across the country and in more than 200 countries and territories worldwide, through a single electronic network for claims processing and reimbursement.

Care within the U.S.

When traveling outside of Michigan, your coverage travels with you. The BlueCard Program gives you access to network and participating providers throughout the U.S.

And like using BCBSM network and participating providers in Michigan, when you use the BlueCard Program you will not have to fill out claim forms or pay up front for the cost of covered services unless it is an out-of-pocket cost, such as a deductible or copay, or a noncovered service.
Here are four steps to make the BlueCard Program work for you:

1. Always carry your current BCBSM ID card.
2. **In an emergency**, go directly to the nearest hospital or doctor.
3. To find nearby doctors and hospitals, call **1-800-810-BLUE** (2583) or visit the BlueCard Doctor and Hospital Finder Web site at [bcbs.com](http://bcbs.com).
4. When you arrive at the network or participating provider’s office or hospital, show the provider your BCBSM ID card. The doctor or hospital will recognize the suitcase logo on your ID card and will know that you are receiving services under the BlueCard Program. This means they will submit any claim forms and only bill you for any deductibles and/or copays required by your health care plan.

**Care outside of the U.S.**

With the BlueCard Worldwide Program, your coverage travels with you to foreign countries. BlueCard Worldwide allows you and your dependents traveling or living abroad to receive covered inpatient hospital care and physician services from a worldwide network of health care providers.

When you need care outside of the United States:

1. Verify your international benefits with your Blue Plan **before** leaving the United States. Coverage may be different outside the country.
2. Always carry your current BCBSM ID card.
3. If you need to find a doctor or hospital, or need medical assistance services, call the **BlueCard Worldwide Service Center** at **1-800-810-BLUE** (select international option) or call collect at **1-804-673-1177** for members calling outside of the United States. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
   - **In an emergency**, go directly to the nearest doctor or hospital.
   - **Note:** If you require hospitalization, an assistance coordinator will obtain written confirmation of your benefits.
   - For **non-emergency** inpatient medical care, you must call the BlueCard Worldwide Service Center to arrange access to a BlueCard Worldwide hospital.

Participating hospitals accept payment guarantees providing cashless access to Blue members for inpatient care when your eligibility and benefits are verified **before** your discharge. **Cashless access** means members will only pay any required deductibles and/or copays and charges for noncovered services upon discharge for inpatient services.

4. If your hospitalization is arranged through the BlueCard Worldwide Service Center, the hospital will file the claim for you. You will need to pay the hospital any deductibles and/or copays required by your health care plan.

5. For outpatient and doctor care or inpatient care **not arranged** through the BlueCard Worldwide Service Center, you will need to pay the provider and submit a claim form with original bills to BCBSM. Try to get all itemized receipts, preferably in English. Blue Cross Blue Shield of Michigan will pay the approved

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**February 2015**
amount for covered services at the rate of exchange in effect on the date of service, minus any deductibles and/or copays required by your health care plan.

Eligibility, enrollment and membership

Your Trust Fund Plan determines the effective date of your health care plan with BCBSM. If you have questions about the date, please contact your Fund Office.

Dependent coverage

Coverage for your dependents, including eligibility criteria, is based on your Trust Fund Plan. For information about eligibility guidelines, contact your Fund Office or reference Section 1 of this SPD.

You can also verify your BCBSM membership records online. Go to bcbsm.com and log in to Member Secured Services.

Making membership changes

To report a membership change for one of the reasons listed below, you will need to contact your Fund Office.

• Name or address change
• Adding or removing a dependent
  Please ensure all individuals listed on your contract are eligible for coverage as your dependent.
• Cancellation of your contract
• Medicare eligibility and enrollment
• Divorce

To avoid delays in payments, misdirected communications or potential coverage problems, it is important that you contact your Fund Office. This is especially important when adding or removing a dependent from your contract because you can be liable for claims paid in error. For example, in the case of divorce, if you fail to give timely notice you may be responsible for payments made by BCBSM on behalf of your ex-spouse for services provided subsequent to your divorce date.

Continuing coverage on your own

Your coverage will end for you and your dependents when you are no longer eligible through your Trust Fund. However, you may continue temporary coverage through COBRA.

For an explanation of COBRA coverage, contact your Fund Office or refer to Section 1 of this SPD. You can also refer to your certificates and riders available online at bcbsm.com. Log in to Member Secured Services. Members without online access may contact BCBSM Customer Service to obtain copies of their certificates and riders. See the Customer service section for information on contacting BCBSM. You can also reference your plan documents or contact your Fund Office.
Certificate of creditable coverage

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

Customer service

Blue Cross Blue Shield of Michigan wants to provide excellent service to you and your family. When you call BCBSM Customer Service, please be ready to provide your contract number (as listed on your BCBSM ID card). If you are inquiring about a claim, you will need to provide the following information:

- Patient’s name
- Provider’s name (hospital, doctor, laboratory, other)
- Date of service and type of service (surgery, office call visit, X-ray, other)
- Provider’s charge for each service

Please remember, BCBSM follows strict privacy policies in accordance with state and federal law. For example, BCBSM will never release your health information to anyone, unless you have authorized BCBSM in writing to do so. You can find the necessary release documents and forms at bcbsm.com.

Call BCBSM

To call BCBSM, please use the phone number on the back of your ID card. You can also find this number on your Explanation of Benefit Payments statement, or EOB. Customer service hours are Monday through Friday from 8:30 to 5 p.m.

Hearing- or speech-impaired members, please call:
Area codes 248, 313, 586, 734, 810 and 947: 313-225-6903
Area codes: 231, 269, and 616: 1-800-867-8980

Visit BCBSM

Visit one of BCBSM’s walk-in customer service centers for personal, face-to-face service. Customer service representatives are available weekdays to assist you. For a list of walk-in customer service centers and hours of operation, go to bcbsm.com or call BCBSM Customer Service.
Write BCBSM

To write BCBSM, please use the address in the upper right-hand corner of your EOB. If you do not have an EOB, call BCBSM Customer Service for assistance.

Claims information

With the Blues’ extensive network of participating providers and the BCBSM BlueCard program, the only time you may have to file your own claims is if you receive services from a nonparticipating, non-network provider.

Filing a claim

If you receive services from a nonparticipating, non-network provider, first ask the provider if he or she will bill BCBSM for the services. Most providers, even those who do not participate with BCBSM, will submit claims to their patients’ health care carriers when asked.

If your provider will not bill BCBSM for you, follow these steps:

1. Ask the provider for an **itemized** statement or receipt with the following information:
   - Patient’s full name (no nickname)
   - Provider’s name, address, phone number and federal tax ID number
   - Date of service
   - Provider’s charge for each service
   - Date and description of services
   - Diagnosis (nature of illness or injury)

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

2. Make a copy of all items for your files, and send the originals to BCBSM at the address listed in the **Customer service** section, under “Write BCBSM” sub-section. It is important that you file your claims promptly because most services have claims filing limitations.
The example below shows the information BCBSM requires in order to review your claim:

<table>
<thead>
<tr>
<th>PHYSICIAN RECEIPT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Name and address of provider</strong></td>
</tr>
<tr>
<td>George S. Smith, M.D.</td>
</tr>
<tr>
<td>100 Market Street</td>
</tr>
<tr>
<td>Hometown, State</td>
</tr>
<tr>
<td><strong>2. Full name of patient</strong></td>
</tr>
<tr>
<td>For professional services to:</td>
</tr>
<tr>
<td>John Smith</td>
</tr>
<tr>
<td><strong>3. Date of service</strong></td>
</tr>
<tr>
<td>DATE OF SERVICE</td>
</tr>
<tr>
<td>CHARGE</td>
</tr>
<tr>
<td>DIAGNOSIS/SERVICE</td>
</tr>
<tr>
<td>5-21-XX</td>
</tr>
<tr>
<td>$75.00</td>
</tr>
<tr>
<td>Anemia/Complete Blood Count</td>
</tr>
<tr>
<td>5-21-XX</td>
</tr>
<tr>
<td>$95.00</td>
</tr>
<tr>
<td>Anemia/Office Visit</td>
</tr>
<tr>
<td>6-11-XX</td>
</tr>
<tr>
<td>$125.00</td>
</tr>
<tr>
<td>Sprained Ankle/ X-Ray, Ankle</td>
</tr>
</tbody>
</table>

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

When payment is made, it will be made directly to the participant. If you have not paid the provider, it is your responsibility to do so.

**Your Explanation of Benefits (EOB)**

Each month BCBSM processes medical claims under your contract number, you will receive an Explanation of Benefit Payments statement, or EOB. This statement is not a bill. At the top of the EOB you will find a BCBSM Customer Service phone numbers and an address to use for inquiries.

An EOB is a record of paid or rejected claims. It also lists any amounts applied to deductibles and/or copays. All health insurance carriers will accept the EOB statement to process any available benefits for coordination of benefits. They can be used to keep track of medical expenses for tax purposes.

**Note:** It is very important for your provider and the Fund Office to have your correct mailing address. In most cases, your EOB will be mailed to the address that is on the BCBSM system. However, if a payment is being sent directly to you, the address that is on the claim form will be used for mailing purposes.
Online EOB statements

Once you have registered at www.BCBSM.com, you will be able to receive your EOB statements online. With online EOBs, you can access your EOB statements safely and securely from any personal computer at any time to track the following:

- Health care services
- Benefit payment histories
- Status of deductibles and copays

Go to bcbsm.com and log in to Member Secured Services to register for online EOBs.

About your EOB

Briefly the EOB tells you:

- The family member who received services
- The date services were provided ("claims processed from...to...")
- "Summary of Balances" includes the provider(s) of the services, details about charges and payments, including the amount saved by using PPO network providers
- "Summary of Deductibles and Copayments" provides your deductible and copay requirements as well as a total of all deductibles and copays paid to date
- "Helpful Information" includes messages and reminders
- "Detail on Services" summarizes the BCBSM payment and shows your balance

If you see an error, contact your provider first. If your provider cannot correct the error, call the customer service number on your EOB.
**EXPLANATION OF BENEFIT PAYMENTS**

**THIS IS NOT A BILL**

Statement Date 06/21/XX

<table>
<thead>
<tr>
<th>Name of Hospital, Physician or Provider</th>
<th>Total Provider Charges</th>
<th>(-) Less BCBSM Paid</th>
<th>(-) Less Participating Provider Savings</th>
<th>(-) Less Other Insurance Paid</th>
<th>(4) Equals Your Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOE, J MD</td>
<td>184.00</td>
<td>66.82</td>
<td>117.18</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Totals**

$184.00 $66.82 $117.18 $0.00 $0.00

**Summary of Balances** (See Detail on Services)

<table>
<thead>
<tr>
<th>Name of Hospital, Physician or Provider</th>
<th>Total Provider Charges</th>
<th>(-) Less BCBSM Paid</th>
<th>(-) Less Participating Provider Savings</th>
<th>(-) Less Other Insurance Paid</th>
<th>Equal Your Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOE, J MD</td>
<td>184.00</td>
<td>66.82</td>
<td>117.18</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Summary of Deductibles and Copayments**

(These totals are based on our information to date and may not reflect all outstanding claims)

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
<th>Date Range</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible required for year:</td>
<td>$300.00</td>
<td>01/01/XX to 12/31/XX</td>
<td>$150.00</td>
</tr>
<tr>
<td>Deductible applied year to date:</td>
<td>$300.00</td>
<td>01/01/XX to 12/31/XX</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

**Helpful Information**

What sets the Michigan Blues apart from some other insurers? The others may drop you when you get sick - or charge you higher premiums. We think that's unfair. The Blues have never done it, and never will.

**Detail on Services**

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Contract Number</th>
<th>Patient: SUSAN</th>
<th>Service Type</th>
<th>Provider Name</th>
<th>Provider Status</th>
<th>Procedure Code</th>
<th>Procedure</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>35/25/XX</td>
<td>123456789</td>
<td>SUSAN</td>
<td>SURGERY</td>
<td>DOE J MD</td>
<td>PARTICIPATING</td>
<td>11300</td>
<td>HAVE SKIN LESION</td>
<td>Savings because provider participates with BCBSM</td>
</tr>
<tr>
<td>36/02/XX</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

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

**Your Customer Service Phone Number Is:**

NATIONWIDE TOLL FREE 1-800 322-4447
DIRECT DIAL 517-322-4447

Send Written Inquiries to this Address:

BLUE CROSS BLUE SHIELD OF MICHIGAN
P.O. BOX 80020
ATTN: MSU DEDICATED SERVICE UNIT

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

**Patient Name or Initial:** SUSAN

**Patient Birth Month/Year:** 09/61

View an example of the EOB statement (pdf)
Coordination of benefits (COB)

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

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

How COB works

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

- Your primary plan is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.
- Your secondary plan is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by both carriers.

Note: To the extent that the services covered under your health care plan are also covered and payable under another group health care plan, BCBSM will combine the BCBSM payment with that of the other plan(s) to pay the maximum amount BCBSM would routinely pay for covered services.

Guidelines to determine primary and secondary plans

The following guidelines are used to determine which carrier pays first:

Contract Holder Versus Dependent Coverage

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

Contract Holder (Multiple Contracts)

If you are the contract holder of more than one health care plan, your primary plan is the one for which you are an active member (such as an employee or participant), and your secondary plan is the one for which you are an inactive member (such as a retiree).
Dependents (The “Birthday Rule”)

If a child is covered under both the mother’s and father’s health care plan, the plan of the parent (or legal guardian) whose birthday (month and day only) is earlier in the year is primary. If the parents’ birthdates are identical, the plan that has covered the dependent longest is primary.

Children of Divorced or Separated Parents

If the child’s parents are divorced, separated or never married, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court order places financial responsibility on one parent:

1. Custodial parent (physical custody)
2. Custodial stepparent (if remarried)
3. Non-custodial parent
4. Non-custodial stepparent (if remarried)

If the primary plan cannot be determined by using the guidelines above, then the “Birthday Rule” will be used to determine primary liability.

Filing secondary COB claims

In most instances when you go to a PPO network or Blues participating provider your provider will bill the primary and secondary carrier directly. However, if you receive services from a nonparticipating provider, and the provider will not file your claim, you will need to file.

Ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or your provider can then submit the claim along with the primary carrier’s payment statement to BCBSM.

When you submit claims to BCBSM for payment of the balance, follow these steps:

1. Obtain an EOB from the primary carrier. Make sure the EOB matches the receipts being submitted.
2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.
4. Make sure the provider’s name and complete address are on all receipts.
   a. If the provider’s office is in Michigan, include the provider’s BCBSM Provider Identification Number (PIN).
   b. If the provider’s office is located outside of Michigan, include the provider’s tax ID number.
5. Keep copies of all statements, receipts and forms for your personal files. Enclose the original billing statement with your claim form.

6. Mail all claims and receipts to:

   Blue Cross Blue Shield of Michigan  
   COB Department  
   600 East Lafayette – Mail Code 610K  
   Detroit, MI 48226-2998

**Important:** If any required information is missing, claims processing may be delayed.

**Updating COB information is your responsibility**

You can avoid claims-processing delays if you keep your COB information updated. View your current COB information online. Go to [bcbsm.com](http://bcbsm.com) and log in to Member Secured Services.

If there are any changes in coverage information for you or your dependents, notify the Fund Office immediately. Blue Cross Blue Shield of Michigan may periodically ask you to update your COB information through a letter of inquiry. Please help BCBSM serve you better by responding to requests for COB information quickly.

**Subrogation**

Your contract with BCBSM contains subrogation language that grants BCBSM the right to recover its payments from responsible third parties. If you file a lawsuit or an insurance claim, or if there is a settlement, subrogation allows BCBSM to hold a party that caused an injury to be responsible for payment of the medical expenses related to the injury.

**Example:** A Blues participant is injured in a store, or other commercial property, due to negligence on the part of the store or property. BCBSM pays for the services to the injured person, as required by their health care contract. Later the member sues the store. The Blues’ subrogation unit would attempt to recover the money paid for medical services in that lawsuit.

The types of cases of third party responsibility BCBSM generally pursues fall into the following categories:

- Workers’ compensation
- Personal injury
- Medical malpractice

In the event that you are injured and a third party is responsible:

- Your right to recover payment from the third party is transferred to BCBSM.
- You are required to do whatever is necessary to help BCBSM enforce its right of recovery.
If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBSM. However, this does not apply if the funds you receive are from additional coverage you purchased in your name from another insurance company.

Please remember that if you hire an attorney to represent you in such a situation, you should always have your attorney call BCBSM at 517-327-4568.

**Appeals**

Every effort is made to process your claims promptly and correctly. If your claim for benefits is denied in whole or in part or if you disagree with a payment, BCBSM will notify you of the status of the claim on your Explanation of Benefit Payments statement, or EOB. To appeal a denial or disputed payment, refer to page 2 of your EOB for directions or contact your Fund Office. Additional information regarding appeals may also be found in this Summary Plan Description, or SPD.

**Frequently asked questions and answers about your PPO plan**

**How can I find a PPO doctor?**

To find a doctor, access the provider directory at [bcbsm.com](http://bcbsm.com) or call the BCBSM Customer Service phone number on the back of your BCBSM ID card. Once you find a doctor, make an appointment with that physician.

**What happens if I don’t like the PPO doctor I select?**

If you don’t like the physician you selected, simply choose another physician. You are not required to notify Blue Cross when you select or change network providers.

**Do I have to use PPO providers?**

**No.** You have the freedom to choose any physician or hospital for the care you need. However, if you receive services from a provider not in the PPO network, you are responsible for paying applicable out-of-network deductibles and copays required by your health care plan. In addition, you may be required to pay an additional charge if the provider you visit is not in the PPO network and does not participate with BCBSM.

A nonparticipating provider may choose not to accept the BCBSM-approved amount as payment in full for covered services. In that case, you would be responsible for paying the difference between the provider’s charge and the BCBSM-approved amount, in addition to out-of-network deductible and copays. You are encouraged to ask the provider if he or she participates with BCBSM before you receive services.

**What is an out-of-network cost?**

An out-of-network cost is the deductible and/or copay your health care plan requires you to pay when you choose to go to a provider not in the PPO network. See the *Choosing your provider* section of this benefit guide for more information.
What if my doctor sends me to a provider outside the PPO network?

The PPO network is designed to meet all your health care needs, including care by specialists. However, in the rare event that a particular service or specialty is not available within the network, your PPO provider may refer you to a provider outside of the PPO network. If you have a referral from your PPO network provider, BCBSM will pay for covered services you receive according to the level of coverage under your health care plan, subject to in-network deductible and copays. See the How your plan works section of this benefit guide for more information.

Note: If you are referred to a non-network, nonparticipating provider, even if you have a referral from a PPO network provider, you are responsible for any difference between the provider’s charge and the BCBSM-approved amount.

When I travel outside of Michigan, am I still covered?

Yes. When traveling outside of Michigan, your coverage travels with you. Through the BCBSM BlueCard program, you have access to network and participating providers throughout the U.S. and around the world. And like participating providers in Michigan, you will not have to fill out any claim forms or pay up front for the cost of covered services unless it is an out-of-pocket cost, such as a deductible or copay, or a noncovered service. When you need medical care while traveling, simply call 1-800-810-BLUE (2583) and you will be referred to the nearest Blue PPO provider or Blue participating provider if there are no PPO providers nearby. See the BlueCard program section of this benefit guide for more information.

What if I need to go to the emergency room?

A medical emergency is a condition that occurs suddenly and unexpectedly, and could result in serious bodily harm or threaten life unless treated immediately. Examples include:

- Heart attack or stroke
- Inability to breathe

An accidental injury is caused by an action, object or substance outside of the body. Examples are:

- Overdosing on medicine or swallowing poison
- Allergic reaction
- Inhaling smoke, carbon monoxide or fumes

Emergency room services for medical emergencies and accidental injuries are covered when the lack of immediate medical attention could result in serious jeopardy to your health. However, there may be limited or no payment for emergency room services that do not meet these standards.

Here’s what to do if you have a medical emergency or accidental injury:

- Always follow the advice of your primary care physician.
If you have an immediate and unforeseen medical emergency and the time to contact your primary care physician may mean permanent damage to your health, you should go directly to the nearest emergency room or call 911 for assistance.

- It is suggested (but not required) that you, the hospital, or someone acting for you, notify your doctor within 48 hours or as soon as it is medically reasonable to do so.
- You should also contact your primary care physician for any follow-up care.

What should I do if I lose my Blue Cross Blue Shield ID card?

If your ID card is lost or stolen, BCBSM will replace it at no cost to you. To request a new card, go to bcbsm.com and log in to Member Secured Services or call your Fund Office or the BCBSM Customer Service phone number on your EOB. See the Your BCBSM ID card section of this benefit guide for more information.

I will retire soon and will go on Medicare. What will happen to my PPO coverage?

At the time you become eligible to enroll in Medicare, your Fund Office may offer you another health care plan that will supplement the coverage provided by Medicare (original Medicare). If this is currently a concern for you, ask your Fund Office about your health care options.

I have no-fault auto coverage. If I am injured in an auto accident, will my PPO plan cover my medical bills?

Your health care plan may or may not provide for services resulting from a motor vehicle accident, including but not limited to automobiles, trucks, buses, motorcycles, etc. One of three options can be chosen by your plan:

- Provide coverage for services related to a vehicular accident
- Provide coverage for services related to a vehicular accident through coordination of benefits between Blue Cross Blue Shield of Michigan and your automobile carrier
- Exclude coverage for all services related to vehicular accidents

If your plan has a motor vehicle/motor cycle exclusion, or modification, information regarding services related to a vehicular accident can be found in your Summary Plan Description, or SPD or Benefit Chart. You should also contact your Fund Office or reference your other plan documents for additional information.

What if my claim is rejected or denied?

Every effort is made to process your claims promptly and correctly. Your Explanation of Benefit Payments statement, or EOB, will indicate if your claim for benefits is denied in whole or in part. To appeal the denial or disputed payment, refer to page 2 of your EOB or contact your Fund Office. Additional information may also be found in your plan documents or SPD.
Glossary

This section explains the terms used in your certificates and riders.

Accidental Injury
Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or another insect bite
- Extreme frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide

Acute Care
Medical care that requires a wide range of medical, surgical, obstetrical and/or pediatric services. It generally requires a hospital stay of less than 30 days.

Acute Care Facility
A facility that provides acute care. This facility primarily treats patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or substance abusers
- Skilled nursing or other nursing care

Administrative Costs for Oncology Clinical Trial
Costs incurred by the organization sponsoring an approved oncology clinical trial. They may include, but are not limited to the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Allogeneic (Allogenic) Transplant
A procedure using another person’s bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.
Ambulatory Surgery

Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a doctor’s office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.

Ambulatory Surgery Facility

A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need to overnight inpatient hospital care. It is not an office of a physician or other private practice office.

Ancillary Services

Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the patient receives. They do not include room, board and nursing care.

Approved Amount

The lower of the billed charge or the BCBSM maximum payment level for the covered service. Deductibles and/or copays, which may be required of you, are subtracted from the approved amount before BCBSM makes its payment.

Arthrocentesis

Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

Attending Physician

The physician in charge of a case who exercises overall responsibility for the patient’s care.

Autologous Transplant

A procedure using the patient’s own bone marrow or peripheral blood stem cells to transplant back into the patient.

BCBSM

Blue Cross Blue Shield of Michigan.

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.
Biological
A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.

Birth Year
A 12-month period of time beginning with a child’s month and day of birth.

BlueCard PPO Program
A program that allows Blue Cross Blue Shield PPO participants to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.

BlueCard Worldwide Program
A program that provides access to a network of inpatient facilities and medical assistance services worldwide including referrals to professional providers for all Blue Cross Blue Shield of Michigan members whose claims are eligible for processing through the BlueCard program.

Blue Cross Plan
Any hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Shield Plan
Any medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

Calendar Year
A period of time beginning January 1 and ending December 31 of the same year.

Carrier
An insurance company providing a health care plan for its members.

Certificate
A Blue Cross Blue Shield of Michigan booklet which describes your benefit plan, adjusted by any riders and/or plan modifications that amend the certificate.

Certified Nurse Midwife
A nurse who provides some maternity services and who:
Is licensed as a registered nurse by the state of Michigan
Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing

Certified Nurse Practitioner
A nurse who provides some medical services and who:
• Is licensed as a registered nurse by the state of Michigan
• Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
• Meets BCBSM qualification standards
• When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

Certified Registered Nurse Anesthetist
A nurse who provides anesthesiology services and who:
• Is licensed as a registered nurse by the state of Michigan
• Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
• Meets BCBSM qualification standards
• When outside the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed

Chronic Condition
A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient’s life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases.

Clinical Trial
A study conducted on a group of patients to determine the effect of a treatment. For purposes of the BCBSM certificate clinical trials include:
• 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.
• Phase III – a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse, or no change in outcome.

Colony Stimulating Growth Factors
Factors that stimulate the multiplication of very young blood cells.
Congenital Condition
A condition that exists at birth.

Contraceptive Medication
Any drug used for the express purpose of preventing pregnancy at the time of its administration.

Contract
The Blue Cross Blue Shield of Michigan certificate and any related riders and plan modifications, if applicable, your signed application for coverage and your BCBSM ID card.

Conventional Treatment
Treatment that has been scientifically proven to be safe and effective for treatment of the patient’s condition.

Coordination Period
A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.

Copayment (or Copay)
The portion of the approved amount that you must pay for a covered service after your deductible, if required, has been met. This can be either a fixed dollar amount (referred to as “fixed dollar copay”) or a percentage amount (referred to as “percent copay”).

Covered Services
The services, treatments or supplies identified as payable in your certificate.

**Note:** To be payable, covered services must be medically necessary, as defined in this section.

Custodial Care
Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, and bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible
The amount you must pay for covered services before benefits are payable.

Dental Care
Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.
Designated Facility
To be a covered benefit, human organ transplants must take place in a “BCBSM-designated” facility. A designated facility is one that BCBSM determines to be qualified to perform a specific organ transplant. BCBSM has a list of designated facilities and will make it available to you and your physician upon request.

Designated Payment Level
The amount used to calculate your BCBSM copay under the BlueCard program. This amount is the lesser of:

- The provider’s billed charges for covered services or
- An amount based on such factors as agreements with the Host Plan’s provider community or historical average reimbursement levels

**Note:** BlueCard program policies permit Host Plans to adjust negotiated prices going forward to correct for overestimation or underestimation of past prices. However, the designated payment level used to calculate your BCBSM copay is considered a final price.

Some state laws require that a special calculation be applied to determine the Host Plan’s payment. In such instances, the designated payment level will reflect any statutory requirements in effect all the time you receive care.

Detoxification
The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

Development Condition
A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.

Dialysis
The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.

Direct Supervision
The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Diversional Therapy
Planned recreational activities, such as hobbies, arts and crafts, etc., not directly related to functional therapy for a medical condition.
Dual Entitlement
When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

Durable Medical Equipment
Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

Effective Date
The date your coverage begins under this contract. This date is established by BCBSM.

Eligibility
As used in Section 1 of this certificate under **End Stage Renal Disease**, eligibility means the member’s right to Medicare coverage under Title XVIII of the Social Security Act, as amended. Otherwise, eligibility means the member’s right to coverage under this certificate.

End Stage Renal Disease (ESRD)
Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal (kidney) failure.

Enrollment Date
The first date of coverage or, if there is a new hire waiting period, the first day of the waiting period.

Entitlement (or Entitled)
The member’s right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.

Exclusions
Situations, conditions, or services that are not covered by the participant’s contract.

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.”

Facility
A hospital or clinic that offers acute care or specialized treatment, such as substance abuse treatment, rehabilitation treatment, skilled nursing care or physical therapy.
Fecal Occult Blood Screening
A laboratory test to detect blood in feces or stool.

First Degree Relative
An immediate family member who is directly related to the patient: either a parent, sibling or child.

First Priority Security Interest
The right to be paid before any other person from money recovered in a verdict, judgment, or settlement of a legal action or settlement that is not part of a legal action.

Flexible Sigmoidoscopy
A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

Freestanding Outpatient Physical Therapy Facility
An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

Group
A collection of participants under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Gynecological Examination
A history and physical examination of the female genital tract.

Hazardous Medical Condition
The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

Health Maintenance Examination
A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination, and health counseling regarding potential risk factors.

Hematopoietic Transplant
A transplant of bone marrow, peripheral blood stem cells, or umbilical cord blood.
Hemodialysis
The use of a machine to clean wastes from the blood after the kidneys have failed.

High Dose Chemotherapy
A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

High Risk Patient
An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers
Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home Health Care Agency
An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient’s home.

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

Hospital
A facility that:
- Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis and
- Is fully licensed and certified as a hospital, as required by all applicable laws and
- 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 of substance abusers
• Skilled nursing facilities or other nursing care facilities

Host Plan
A Blue Cross and/or Blue Shield plan outside of Michigan that participates in the BlueCard PPO program and processes claims for services that you receive in that state.

Independent Physical Therapist
A physical therapist who provides some physical therapy services and who:
• Is licensed as a physical therapist by the state of Michigan
• Meets BCBSM qualification standards

When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Infusion Therapy
The continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

Injectable Drugs
Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician’s supervision.

Irreversible Treatment
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.
• The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
• The treatment is intended to cause permanent change to a person's bite or position of the jaws.
• The treatment includes, but is not limited to:
  • Crowns, inlays, caps, restorations and grinding
  • Orthodontics, such as braces, orthopedic repositioning and traction
  • Installation of removable or fixed appliances such as dentures, partial dentures or bridges
  • Surgery directly to the jaw joint
  • Arthrocentesis
Jaw Joint Disorders

These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly
- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain and inability to move the jaw properly
- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly

Lien

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid as a result of the plaintiff’s injuries.

Lobar Lung

A portion of a lung from a cadaver or living donor.

Long-Term Acute Care Hospital (LTACH)

A specialty hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

Mammogram

A low dose X-ray of the breast, two views per breast. The radiation machine must be state-authorized and specifically designed and used to perform mammography.

Mandibular Orthotic Reposition Device

An appliance used in the treatment of temporomandibular joint dysfunction.

Maternity Care

Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial Prosthesis

A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Medical Emergency

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

A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD patient beginning dialysis.

Medically Necessary

A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and Long Term Acute Care Hospitals (LTACHs); and a third applies to other providers.

- **Medical necessity for payment of professional provider services:**

  Health care services that a professional 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:

  - In accordance with generally accepted standards of medical practice;
  - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member’s illness, injury or disease and
  - 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 services of other providers:**

  Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

  - The covered service is accepted as necessary and appropriate for the patient’s condition. It is not mainly for the convenience of the member or physician.
  - In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

  **Note:** In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.
• **Medical necessity for payment of hospital and LTACH services:**
  
  Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:
  
  • The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
  • The service, treatment, or supply is appropriate for the symptoms and is consistent with the diagnosis.
    • **Appropriate** means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
    • For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
  • The service is not mainly for the convenience of the member or health care provider.
  • The treatment is not generally regarded as experimental by BCBSM.
  • The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

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**Member**

Any person eligible for health care services under the health care plan certificate on the date the services are rendered. This means the participant and any eligible dependent listed on the application. The member is the "patient" when receiving covered services.

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**Network Providers**

Hospitals, physicians and other licensed facilities or health care professionals who provide services through the BCBSM PPO program. Network providers have agreed to accept the BCBSM-approved amount as payment in full for covered services provided under the BCBSM PPO program.

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**Non-Network Providers**

Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under the BCBSM PPO program.

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**Nonparticipating Providers**

Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

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**Occupational Therapy**

A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:
• Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury or following surgery

• Help the patient learn to apply the newly restored or improved function to meet the demands of daily living, or

• Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, shower chairs, large-handle eating utensils, lap trays and raised toilet seats)

Off-Label
The use of a drug or device for clinical indications other than those stated in the labeling approved by the federal Food and Drug Administration.

Orthopedic Shoes
Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

Orthotic Device
An appliance worn outside the body to correct a body defect of form or function.

Out-of-Area Services
Services available to members living or traveling outside a health plan’s service area.

Outpatient Mental Health Facility
A facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.

Outpatient Substance Abuse Treatment Program
A program that provides medical and other services on an outpatient basis specifically for substance abusers.

Pap Smear
A method used to detect abnormal conditions, including cancer of the female genital tract.

Partial Liver
A portion of the liver taken from a cadaver or living donor.
Participating PPO Provider

A provider who participates with the Host Plan’s PPO.

Participating Providers

Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copays and/or deductibles, which may be required of you, are subtracted from the approved amount before BCBSM makes its payment.

Patient

The participant or eligible dependent that is awaiting or receiving medical care and treatment.

Per Claim Participation

Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

Peripheral Blood Stem Cell Transplant

A procedure in which blood stem cells are obtained by pheresis and infused into the patient’s circulation.

Peritoneal Dialysis

Removal of wastes from the body by perfusion of a chemical solution through the abdomen.

Pheresis

Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).

Physical Therapy

The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient’s specific muscles or joints to restore or improve:

- Muscle strength
- Joint motion
- Coordination
- General mobility
Physician
A doctor of medicine, osteopathy, podiatry, chiropractic, or an oral surgeon. Physicians may also be referred to as “practitioners.”

Plaintiff
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Practitioner
A physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master’s social worker, or oral surgeon) or other professional provider who participates with BCBSM or who is on a BCBSM PPO panel. Practitioner may also be referred to as “participating” or “network” provider.

Pre-existing Condition
A condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date.

Preferred Provider Organization (PPO)
A limited group of health care providers who have agreed to provide services to BCBSM members enrolled in the PPO program. These providers accept the approved amount as payment in full for covered services.

Presurgical Consultation
A consultation that allows a member to get an additional opinion from a physician who is a doctor of medicine, osteopathy, podiatry or an oral surgeon when surgery is recommended.

Primary Payer
The health care coverage plan that pays first when you are provided benefits by more than one carrier. (For example, you may have BCBSM group coverage and Medicare.)

Primary Plan
The health care plan obligated to pay for services before any other health care plan that covers the member or patient.

Professional Provider
One of the following:
- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
Podiatrist
Chiropractor
Fully licensed psychologist
Clinical licensed master’s social worker
Oral surgeon
Other providers as identified by BCBSM

Professional providers may also be referred to as “practitioners.”

Prosthetic Device
An artificial appliance that:
- Replaces all or part of a body part or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ

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

Psychiatric Day Treatment
Treatment for mental or emotional disorders given to a patient who lives at home and goes to a facility for each day of treatment.

Psychiatric Night Treatment
Treatment for mental or emotional disorders given to a patient who lives at home, but goes to a facility at night for treatment and is given meals and a bed.

Psychologist
A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Purging
A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Qualified Beneficiary
Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).
Qualifying Event
One of the following events that allows a qualified beneficiary to receive COBRA coverage:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

Radiology Services
These include X-ray exams, radium, radon, cobalt therapy, ultra-sound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

Refractory Patient
An individual who does not achieve clinical disappearance of the disease after standard therapy.

Relapse
When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient’s condition.

Remitting Agent
Any individual or organization that has agreed, on behalf of the participant, to:

- Collect or deduct premiums from wages or other sums owed to the participant and
- Pay the participant’s BCBSM bill

Research Management
Services, such as diagnostic tests, which are performed solely to support the sponsoring organization’s research. They are not necessary for treating the patient’s condition.

Residential Substance Abuse Treatment Program
A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called “intermediate care.”

Respite Care
Relief to family members or other persons caring for terminally ill persons at home.
Reversible Treatment

Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- This treatment is not intended to cause permanent change to a person's bite or position of the jaws.
- This treatment is designed to manage the patient’s symptoms. It can include, but is not limited to, the following services:
  - Arthrocentesis
  - Physical therapy (see your certificate for physical therapy services)
  - Reversible appliance therapy (mandibular orthotic repositioning)

Rider

A document that changes a certificate by adding, limiting, deleting or clarifying benefits.

Right of Reimbursement

The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Screening Services

Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.

Secondary Plan

The health care plan obligated to pay for services after the primary plan has paid for services.

Self-Dialysis Training

Teaching a member to conduct dialysis on himself or herself.

Semiprivate Room

A hospital room with two beds.

Service Area

The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

Note: BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers’
claims will not be subject to BlueCard rules.

Services
Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.

Skilled Care
A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:
- Ordered by the attending physician
- Medically necessary according to generally accepted standards of medical practice
- Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician

Skilled Nursing Facility
A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Small Bowel Transplant
A procedure in which the patient’s small intestine is removed and replaced with the small intestine of a cadaver.

Special Foods for Metabolic Disease
Special medical foods that are formulated for the dietary treatment of an inherited metabolic disease. The nutritional requirements of the patient are established by medical evaluation and the diet is administered under the supervision of a physician. These formulations are exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration.

Special infant formulas are liquid feedings used for the treatment of inherited metabolic diseases. These formulas can provide up to 85 percent of the protein, vitamin and mineral needs of an infant.

A low-protein modified food product is one specially formulated to provide less than one gram of protein per serving. It is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, but does not include a food that is naturally low in protein.

Specialty Hospitals
Hospitals that treat specific diseases, such as mental illness.
Specialty Pharmaceuticals

Biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Specialty Pharmacy

Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech and Language Pathology Services

Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Stabilize

Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child [including the placenta]).

Stem Cells

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

Subrogation

The assumption by BCBSM of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Substance Abuse

Taking alcohol or other drugs in amounts that can:

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

Substance abuse is alcohol or drug abuse or dependence as classified in Categories 303.3 – 305.0 and 305.2 – 305.9 of the most current edition of the “International Classification of Diseases.”

Substance Abuse Treatment Program Services

Subacute services to restore a person’s mental and physical well-being when the person is a substance abuser. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.
Syngeneic Transplant
A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient’s identical twin to transplant into the patient.

Tandem Transplant
A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and if the patient’s cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.

T-Cell Depleted Infusion
A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow, or umbilical cord blood.

Technical Surgical Assistance
Professional active assistance given to the operating physician during surgery by another physician not in charge of the case.

**Note:** Professional active assistance requires direct physical contact with the patient.

Terminally Ill
A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

Therapeutic Shoes
Therapeutic or diabetic shoes are prescribed by a physician or certified nurse practitioner and are either “off-the-shelf” or custom-molded shoes which assist in protecting the diabetic foot.

Total Body Irradiation
A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

Treatment Plan
A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under integrated case and disease management. The treatment plan may include medically necessary services that BCBSM determines should be provided because of the member’s condition as specified in the plan, even if those services are not covered under the patient’s hospital and professional.
certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member’s physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

Urgent Care
Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or doctors’ offices.

Valid Application
An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.

Waiting Period
Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.

Ward
A hospital room with three or more beds.

We, Us, Our
Used when referring to Blue Cross Blue Shield of Michigan.

Well-Baby Care
Services provided in physician’s office to monitor the health and growth of a healthy child.

Working Aged
Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse’s current employment.

Working Disabled
Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.

You and Your
Used when referring to any person covered under the participant’s contract.
Section 3. Medical Benefits – Active Participants

Schedule of Benefits for Active Participant Benefits

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM’s approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders if your group is underwritten or any other plan documents your group uses if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: To be eligible for coverage, the following services require your provider to obtain approval before they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – Select specialty pharmaceuticals do not require preauthorization.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Eligibility Information

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependents</td>
<td>☒ Subscriber’s legal spouse</td>
</tr>
<tr>
<td></td>
<td>☒ Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26</td>
</tr>
<tr>
<td>No-fault motor vehicle accidents</td>
<td>Coverage is excluded for all services related to an injury which is a direct or indirect result of any motor vehicle accident, including but not limited to automobiles, motorcycles, buses, and trucks. This applies whether or not the individual has no-fault insurance. Please see page seventy-three (73) for the complete exclusion</td>
</tr>
</tbody>
</table>
Comprehensive Major Medical Blue Preferred – PPO

**Note:** Services from a provider for which there is no Michigan PPO network are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between BCBSM’s approved amount and the provider’s charge.

**CMM-PPO In-Network** – Providers who have contracted with BCBSM’s PPO program are termed “participating” or “in-network” providers. In other words, these providers are part of the PPO network. If you use the services of a PPO network provider, you will be responsible only for applicable copays for approved services.

**CMM-PPO Out-of-Network** – Providers who have not contracted with BCBSM’s PPO program are considered “out-of-network” providers. If you choose an “out-of-network” provider for services, you will be responsible for higher copays plus any amount charged by the provider that is greater than BCBSM’s payment if the provider is also not part of BCBSM’s Traditional Network. Please note that these balances could be substantial. If a PPO provider “refers” you out-of-network to a BCBSM Traditional participating provider, you will be liable for copays only. However, if you are referred to a provider who does not participate in BCBSM’s Traditional or PPO Network, you will be responsible for copays plus costs greater than BCBSM’s payment.

<table>
<thead>
<tr>
<th>Member’s responsibility (deductibles, copays, coinsurance and dollar maximums)</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Out-of-Pocket Maximums (These amounts may change annually)</strong>&lt;br&gt;This is the maximum amount you’ll have to pay each year for covered medical services. This includes coinsurance and fixed dollar copays.</td>
<td>$6,350 Individual/ $12,700 Family (Does not count Towards Out-of-Network, Out-of-Pocket Maximums)</td>
<td>$6,350 Individual / $12,700 Family (Does not count Towards In-Network, Out-of-Pocket Maximums)</td>
</tr>
<tr>
<td><strong>Deductibles</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Fixed dollar copays</strong></td>
<td>$20 copay for select office visits</td>
<td>$20 copay for select office visits</td>
</tr>
<tr>
<td><strong>Percent copays</strong></td>
<td>20% of approved amount for most covered services</td>
<td>• 30% of approved amount for most other covered services</td>
</tr>
<tr>
<td><strong>Annual copay dollar maximums – excludes fixed dollar copays and private duty nursing percent copays</strong></td>
<td>$1,200 per contract each calendar year</td>
<td>$1,000 per contract each calendar year, in addition to the $1,200 in-network copay dollar maximum for percent copays</td>
</tr>
<tr>
<td><strong>Lifetime dollar maximum</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care services</td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Gynecological exam</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Pap smear screening – laboratory and pathology services</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Voluntary sterilizations for females</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of the approved amount</td>
</tr>
<tr>
<td>Contraceptive injections</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of the approved amount</td>
</tr>
<tr>
<td>Well-baby and child care visits</td>
<td>100% (no copay)</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>• 6 visits, birth through 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits, 13 months through 23 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits, 24 months through 35 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 visits, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Visits beyond 47 months are limited to one per individual per calendar year under the health maintenance exam benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Fecal occult blood screening</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy exam</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) screening</td>
<td>100% (no copay) One per individual per calendar year</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>
### MICHIGAN LABORERS’ HEALTH CARE FUND
Summary Plan Description

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening CA-125 tests</td>
<td>100% (no copay)</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td></td>
<td>One per individual per calendar year</td>
<td></td>
</tr>
<tr>
<td>Routine mammogram and related reading</td>
<td>100% (no copay)</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Note: Subsequent medically</td>
<td></td>
<td></td>
</tr>
<tr>
<td>necessary mammograms performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>during the <strong>same</strong> calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>are subject to your percent copay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One per individual per calendar year</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy – routine or medically necessary</td>
<td>100% (no copay) for the first billed colonoscopy</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Note: Subsequent colonoscopies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>performed during the <strong>same</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>calendar year are subject to your</td>
<td></td>
<td></td>
</tr>
<tr>
<td>percent copay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One per individual per calendar year</td>
<td></td>
</tr>
</tbody>
</table>

#### Physician office services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
<td>$20 copay per office visit</td>
<td>$20 copay per office visit</td>
</tr>
<tr>
<td></td>
<td><strong>and the</strong> additional 30% of approved amount</td>
<td></td>
</tr>
<tr>
<td>Outpatient and home medical care visits</td>
<td>$20 copay per office visit</td>
<td>$20 copay per office visit</td>
</tr>
<tr>
<td></td>
<td><strong>and the</strong> additional 30% of approved amount</td>
<td></td>
</tr>
<tr>
<td>Office consultations</td>
<td>$20 copay per office visit</td>
<td>$20 copay per office visit</td>
</tr>
<tr>
<td></td>
<td><strong>and the</strong> additional 30% of approved amount</td>
<td></td>
</tr>
<tr>
<td>Urgent care visits</td>
<td>$20 copay per office visit</td>
<td>$20 copay per office visit</td>
</tr>
<tr>
<td></td>
<td><strong>and the</strong> additional 30% of approved amount</td>
<td></td>
</tr>
</tbody>
</table>

#### Emergency medical care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Physician’s office</td>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

February 2015

Section 3. Medical Benefits – Active Participants
### Diagnostic services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and pathology services</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Diagnostic tests and x-rays</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Therapeutic radiology</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Maternity services provided by a physician or certified nurse midwife

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care</td>
<td>100% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Delivery and nursery care</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Hospital care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td><strong>Note:</strong> Nonemergency services must be rendered in a participating hospital.</td>
<td><strong>Unlimited days</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient consultations</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Alternatives to hospital care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing care – must be in a participating skilled nursing facility</td>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Hospice care</td>
<td>100% (no copay)</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)</td>
<td><strong>Unlimited days</strong></td>
<td></td>
</tr>
<tr>
<td>Home health care – must be medically necessary and provided by a participating home health care agency</td>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers</td>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>
### Surgical services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery – includes related surgical services</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td><strong>Note:</strong> BCBSM will pay for medically necessary facility services only in a BCBSM participating ambulatory surgery facility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presurgical consultations</td>
<td>$20 copay per visit</td>
<td>$20 copay per visit and the additional 30% of approved amount</td>
</tr>
<tr>
<td>Voluntary sterilization for males</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td><strong>Note:</strong> See “Preventive care services” section for voluntary sterilizations for females.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Human organ transplants

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</td>
<td>100% (no copay) – in designated facilities only</td>
<td></td>
</tr>
<tr>
<td>Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Specified oncology clinical trials</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Kidney, cornea and skin transplants</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Mental health care and substance abuse treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health care</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Inpatient substance abuse treatment</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Outpatient mental health care</td>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
<tr>
<td>Outpatient substance abuse treatment – In-approve facilities only</td>
<td>80% of approved amount</td>
<td>70% of approved amount (in-network cost-sharing will apply if there is no PPO network)</td>
</tr>
</tbody>
</table>
### Autism spectrum disorders, diagnoses and treatment

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

Applied behavioral analyses (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization.

**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.

### Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Other covered services, including mental health services, for autism spectrum disorder

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Other covered services

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% (no copay) for diabetes self-management training by a participating provider</td>
<td>70% of approved amount for diabetes medical supplies</td>
</tr>
</tbody>
</table>

**Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider.

### Outpatient Diabetes Management Program (ODMP)

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

### Allergy testing and therapy

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Chiropractic spinal manipulation

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 copay per visit</td>
<td>$20 copay per visit and the additional 30% of approved amount</td>
</tr>
</tbody>
</table>

**Note:** Limited to a maximum of 27 visits per individual per calendar year.

### Outpatient physical, speech and occupational therapy

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>

### Durable medical equipment

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

**Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider.

### Prosthetic and orthotic appliances

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

### Private duty nursing

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

### Nail debridement

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of approved amount</td>
<td>70% of approved amount</td>
</tr>
</tbody>
</table>
The following services are excluded and are Non-Payable:

<table>
<thead>
<tr>
<th>Hospital and Facility Care Inpatient Services Non-Payable:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services received in a non-participating hospital or facility.</td>
</tr>
<tr>
<td>Services that may be medically necessary but can be provided safely in an outpatient of office location.</td>
</tr>
<tr>
<td>Custodial care or rest therapy.</td>
</tr>
<tr>
<td>Psychological tests if used as part of, or in connection with, vocational guidance training or counseling.</td>
</tr>
<tr>
<td>Human organ transplants except for the following: kidney, cornea, skin bone marrow, combined small intestine-liver, heart, heart-lung(s), liver, lobar lung, lung(s), pancreas, partial liver, kidney-liver, simultaneous pancreas-kidney, small intestine (small bowel), multivisceral transplants (as determined by BCBSM).</td>
</tr>
<tr>
<td>Dental services except as follows: Facility and anesthesia services may be payable if a hospitalized patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. In these cases, services are covered for the facility and anesthesia services only, not for the services of a dentist or other dental professional.</td>
</tr>
<tr>
<td>Screening services while in-patient.</td>
</tr>
<tr>
<td>Services covered under any other Blue Cross or Blue Shield contract or under any health care benefits plan except for Coordination of Benefits.</td>
</tr>
<tr>
<td>Dental implants and related services, including repair and maintenance of implants and surrounding tissue.</td>
</tr>
<tr>
<td>Non-contractual services through case management treatment plans when such services have not been approved by BCBSM.</td>
</tr>
<tr>
<td>No-fault motor vehicle accidents</td>
</tr>
</tbody>
</table>

Hospital admissions that are not covered by the BCBSM certificate as follows:

<table>
<thead>
<tr>
<th>Care that is not considered acute such as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
</tr>
<tr>
<td>Dental treatment, including extraction of teeth except as noted above</td>
</tr>
<tr>
<td>Diagnostic evaluations</td>
</tr>
<tr>
<td>Lab exams</td>
</tr>
<tr>
<td>Electrocardiography</td>
</tr>
<tr>
<td>Weight reduction</td>
</tr>
<tr>
<td>X-rays, exams or therapy</td>
</tr>
<tr>
<td>Cobalt or ultrasound studies</td>
</tr>
<tr>
<td>Basal metabolism tests</td>
</tr>
<tr>
<td>Convalescence or rest care</td>
</tr>
<tr>
<td>Convenience care</td>
</tr>
<tr>
<td>Hospital Services mainly for physical therapy, speech and language pathology services or occupational therapy.</td>
</tr>
</tbody>
</table>
### Hospital and Facility Care Outpatient Services Non-Payable:

- Services for mental health care that is beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient’s condition according to generally accepted professional standards or in a skilled nursing facility.
- Services in a non-participating ambulatory surgery facility.
- Services provided by a non-participating end stage renal disease facility.
- Services not provided by the employees of an end stage renal disease facility.
- Services not related to end stage renal disease dialysis processes.
- Home Health Care Services Non-Payable are: general housekeeping services, transportation to and from a hospital or other facility, custodial care or non-skilled care, services performed by a non-participating home health care provider.

### Other Non-Payable Providers:

- Non-participating hospitals (except for emergency services at an accredited non-participating hospital), facilities or alternative to hospital care providers. Emergency services are paid at BCBSM’s approved amounts.
- Services at non-participating outpatient physical therapy facilities, freestanding ambulatory surgery facilities, mental health or substance abuse treatment facilities, skilled nursing facilities, hospice programs, home health care agencies, infusion therapy providers.

### Other Non-Payable Services:

- Services that are covered by any other BCBSM certificate or under any other health care benefits plan except for Coordination of Benefits.
- Services that are not covered because they are medically unnecessary or experimental.

### Physician Services Non-Payable:

- Services for cosmetic surgery when performed solely to improve appearance.
- Services provided by persons who are not eligible for payment or appropriately credentialed or legally authorized or licensed to order or provide such services.
- Dental care except to treat an accidental injury or if an inpatient due to a medical necessity.
- Pre-employment, pre-marital, school and sports physicals unless needed to diagnose or treat a specific disease, illness, pregnancy or injury.
- Weight loss programs.
- Services in a non-hospital institution except for approved home health care.
- Services, care, supplies or devices not prescribed by a physician.
- Non-contractual services described through a case management treatment plan not approved by BCBSM.
- Services provided during non-emergency medical transport.
- Experimental treatment.
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient’s condition according to generally accepted professional standards.
- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances unless you lack a natural lens.
- Irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction except for surgery directly to the temporomandibular joint and related anesthesia.

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February 2015

Section 3. Medical Benefits – Active Participants Page 71
services, diagnostic x-rays, arthrocentesis, approved physical therapy.

Self-treatment by a professional provider and services given to parents, siblings, spouse or children.

Alternative medicines or therapies such as acupuncture, herbal medicines and massage therapy.

Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient’s endurance while exercising and management of risk factors are stable.

Infertility services that do not treat a medical condition other than infertility 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.

Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue, unless otherwise noted as an included benefit.

Rest therapy or services provided while in a convalescent home, long term care facility, nursing home, rest home or similar non-hospital institution.

Sports medicine, pain management, patient education (except as otherwise specified) or home exercise programs.

Screening services (except as otherwise stated).

Services for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under your Certificate.

Services available in a hospital maintained by the state or federal government, unless payment is required by law.

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

Services not listed in your Certificate as being payable.

Devices and Services Non-Payable:

- Non-rigid devices and supplies such as elastic stockings, garter belts, arch supports and corsets.
- Spare prosthetic devices.
- Routine maintenance of the prosthetic device.
- Prosthetic devices that are experimental.
- Hair prostheses such as wigs, hair pieces, hair implants, etc.
- Hearing aids or services to examine, prepare, fit or obtain hearing aids.
## No-Fault Auto Insurance

If you or an eligible dependent are involved in a motor vehicle accident, Michigan Laborers’ Health Care Fund will not pay for services related to an injury which is a direct or indirect result of an automobile accident. This applies whether or not you have no-fault automobile insurance.

In addition, the Michigan Laborers’ Health Care Fund will be secondary to motorcycle insurance when services are provided to treat an injury or condition that is a result of a motorcycle accident that is not a motor vehicle accident when the Member carries or is required to carry motorcycle insurance, regardless of whether a helmet was worn by the driver and/or passenger. In no event will benefits be covered for an injury or condition of a Member who rides without a helmet and is injured in a non-motor vehicle accident until after the first $20,000 of expenses is paid by the motorcycle insurance carrier with respect to Member riders who are required by Public Act 98 to carry motorcycle insurance.

If such Member does not carry the required insurance and the Member is injured while riding a motorcycle in an accident that is not a motor vehicle accident, then the Member's claims arising out of that accident are completely excluded. Payments for services to any provider made prior to discovery by BCBSM or the group health plan that the services arose as a result of the Member’s injury in a motorcycle accident that is not a motor vehicle accident for which insurance is carried or required to be carried will be recovered from the provider(s). Payment for these services would then become the member’s responsibility or the responsibility of the member’s motorcycle insurance carrier.
Section 4. Blue Preferred Rx

Blue Preferred® Rx Prescription Drug Coverage - For Active, Pre-Medicare & Post Medicare Retirees

Specialty Pharmaceutical Drugs – The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). A list of specialty drugs is available on our Web site at bcbsm.com. Log in under I am a Member. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a “specialty pharmaceutical”. BCBSM may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Note: Mail order or 90-Day Retail Prescriptions are not covered.

<table>
<thead>
<tr>
<th>Member’s responsibility (copays)</th>
<th>Network pharmacy</th>
<th>Non-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic plus the applicable copay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 – Generic drugs</td>
<td>$10 copay</td>
<td>$10 copay plus an additional 25% of BCBSM approved amount for the drug</td>
</tr>
<tr>
<td>Tier 2 – Formulary (preferred) brand-name drugs</td>
<td>$40 copay</td>
<td>$40 copay plus an additional 25% of BCBSM approved amount for the drug</td>
</tr>
<tr>
<td>Tier 3 – Nonformulary (nonpreferred) brand-name drugs</td>
<td>$60 copay</td>
<td>$60 copay plus an additional 25% of BCBSM approved amount for the drug</td>
</tr>
</tbody>
</table>

Note: A network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. A non-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.
<table>
<thead>
<tr>
<th>Covered services</th>
<th>Network pharmacy</th>
<th>Non-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA-approved drugs</td>
<td>100% of approved amount less plan copay</td>
<td>75% of approved amount less plan copay</td>
</tr>
<tr>
<td>State-controlled drugs</td>
<td>100% of approved amount less plan copay</td>
<td>75% of approved amount less plan copay</td>
</tr>
<tr>
<td>FDA-approved <strong>generic</strong> prescription contraceptive medication (non-self-administered drugs and devices are not covered)</td>
<td>100% of approved amount</td>
<td>75% of approved amount less plan copay</td>
</tr>
<tr>
<td>FDA-approved <strong>brand name</strong> prescription contraceptive medication (non-self-administered drugs and devices are not covered)</td>
<td>100% of approved amount less plan copay</td>
<td>75% of approved amount less plan copay</td>
</tr>
<tr>
<td>Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs</td>
<td>100% of approved amount less plan copay for the insulin or other covered injectable legend drug</td>
<td>75% of approved amount less plan copay for the insulin or other covered injectable legend drug</td>
</tr>
</tbody>
</table>

**Note:** Needles and syringes have no copay.

**Features of your prescription drug plan**

**BCBSM Custom Formulary**

A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost.

**Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment.

**Tier 2 (preferred brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay.

**Tier 3 (nonpreferred brand)** – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or are high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.
**Mandatory maximum allowable cost drugs**

If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you **MUST** pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the **maximum allowable cost** for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay.

**Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

<table>
<thead>
<tr>
<th><strong>Elective drugs</strong></th>
</tr>
</thead>
</table>

Excludes coverage for elective lifestyle drugs.  

**Note:** Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.

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**Prescription Drugs Not Covered**

More than a 30-day supply of a covered drug. BCBSM may make exceptions for certain maintenance drugs or for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers). This also applies to “specialty pharmaceuticals” unless an exception is make by BCBSM because of a requirement for more than a 30-day supply.

Therapeutic devices or appliances including, but not limited to, hypodermic or disposable needles and syringes when not dispensed with a covered injectable drug, insulin or self-administered chemotherapeutic drugs.

Drugs prescribed for cosmetic purposes.

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.

Any vaccine given solely to resist infectious diseases. (please check your medical benefits)

Administration of covered drugs (e.g., injections) or routine immunizations.

Non-self-administered injectable drugs.

More than a 30-day supply of a covered drug. BCBSM may make exceptions for certain maintenance drugs or for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers).

More than 12 doses of an impotence drug in a 30-day period unless otherwise noted or excluded.

More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescribing physician obtains preauthorization from BCBSM. A list of drugs that may have quantity and/or dose limits is available at the BCBSM Web site at bcbsm.com.

Any drug BCBSM determines to be experimental or investigational.

Any covered drug entirely consumed at the time and place of the prescription.

Anything other than covered drugs and services.

Diagnostic agents.
Any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off-label use of a drug or device. Some chemotherapeutic drugs may be subject to prior authorization review.

Drugs that are not labeled FDA-approved, except for state-controlled drugs and insulin, or such drugs the BCBSM designates as covered.

Covered drugs or services dispensed to a member when such services are benefits under other Blue Cross and Blue Shield certificates.

Drugs or services obtained before the effective date of this contract, or after the contract ends.

Nonpreferred co-branded drugs, unless they are preauthorized.

Claims for covered drugs or services submitted after the applicable time limit for filing claims.

Support garments or other nonmedical items.
Section 5. Dental Coverage

Custom Series K-1000 Dental Coverage – For Active, Pre-Medicare & Post Medicare Participants (Participants Remitting Self-Payments Must Elect to Remit Self-Payments that Include Dental Benefits)

<table>
<thead>
<tr>
<th>Member’s responsibility (deductible, copays and dollar maximums)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
</tr>
<tr>
<td><strong>Copays</strong></td>
</tr>
<tr>
<td>• Class I services</td>
</tr>
<tr>
<td>• Class II services</td>
</tr>
<tr>
<td>• Class III services</td>
</tr>
<tr>
<td>• Class IV services</td>
</tr>
<tr>
<td><strong>Dollar maximums</strong></td>
</tr>
<tr>
<td>• Annual maximum for Class I, II and III services</td>
</tr>
<tr>
<td>• Lifetime maximum for Class IV services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class I services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral exams – once every six consecutive months</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Teeth cleaning – once every six consecutive months</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Bitewing x-rays – once every six consecutive months</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Full-mouth x-rays – once every 36 consecutive months</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Palliative (emergency) treatment</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Fluoride treatments</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>80% of approved amount, up to age 19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class II services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings (amalgam, acrylic or silicate)</td>
<td>50% of approved amount</td>
</tr>
<tr>
<td>Inlays, onlays, crowns, and veneers</td>
<td>50% of approved amount</td>
</tr>
<tr>
<td>Root canal therapy</td>
<td>50% of approved amount</td>
</tr>
<tr>
<td>Periodontic treatments</td>
<td>50% of approved amount</td>
</tr>
<tr>
<td>General anesthesia</td>
<td>50% of approved amount</td>
</tr>
<tr>
<td>Oral surgery including extractions</td>
<td>50% of approved amount</td>
</tr>
<tr>
<td>Repairs to existing dentures</td>
<td>50% of approved amount</td>
</tr>
</tbody>
</table>
### Class III services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removable dentures</td>
<td>50% of approved amount</td>
</tr>
<tr>
<td>Fixed bridges</td>
<td>50% of approved amount</td>
</tr>
</tbody>
</table>

### Class IV services – Orthodontic services for dependents under age 19

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habit breaking appliances</td>
<td>Not covered</td>
</tr>
<tr>
<td>Minor tooth guidance appliances</td>
<td>Not covered</td>
</tr>
<tr>
<td>Full-banding treatment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Monthly, active treatment visits</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Note:** For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination *before* treatment begins. If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist’s charge.

### Dental Benefits Not Covered

- Dental services performed for reversible or irreversible treatment of temporomandibular joint (jaw joint) dysfunction, except for:
  - Limited diagnostic X-rays and subsequent orthodontic treatment

  **Note:** The above restriction applies no matter what caused the temporomandibular joint (jaw joint) dysfunction.

- Devices for the diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction such as mandibular orthotic reposition devices

- Charges for missed appointments

- Services and supplies that are not necessary for diagnosing or treating a dental condition or injury or were not recommended and approved by the attending dentist

- Services that are experimental, investigational or do not meet standards of the profession

- Services solely for cosmetic purposes, personalized or customized services or supplies (for example, bonding or veneers when there is no decay or fracture, or bleaching of teeth)

- Charges for instruction in oral hygiene, diet, plaque control programs and dental sealants

- Care received at a medical or dental clinic provided or maintained by an employer

- Services covered by workers compensation laws

- Services covered by government-sponsored health care programs, such as Medicare

- Services received for dental diseases or injuries resulting from declared or undeclared acts of war

- Services provided or started before the effective date of coverage

- Services provided after coverage ends. An exception is for a crown, onlay, veneer, bridge or denture if:
  - It is “ordered” or final impressions have been completed before coverage ends
  - The procedure or appliance is completed and delivered within 60 days of the date coverage ended

The more costly treatment when two or more methods are available to treat a condition. BCBSM pays the approved amount, less the required copayment and deductible, if any, for the less costly acceptable standard of treatment

- Treatment by other than a dentist or oral surgeon, except for treatment provided by a licensed dental hygienist
under the supervision of a dentist and within the scope of his or her license

Services or supplies for which no charge is made or that you are not legally obligated to pay. Charges that would not be made if you did not have coverage, such as charges for self-treatment (dentist treating himself or herself) or the dentist’s family members

Services by a student at a dental or medical school that is outside the State of Michigan

Facility fees or any additional hospital related charges that a dentist, physician or hospital charges for treating a patient at a hospital

Oral medications, Topically applied antibiotics, non-antibiotic injections, prescriptions and other drugs

Premedication, local anesthetic or analgesic billed as a separate service

Infection control and barrier techniques

Supplies and equipment for use at home, such as mouth trays and electric toothbrushes

Desensitizing medications

Restorations to adjust or restore missing tooth structure due to abrasion, attrition or erosion, except for individual consideration by report

Restorations to stabilize the teeth or to correct the vertical dimension; to strengthen a tooth, prevent a future problem or close a space

Diagnostic mounted case analysis for reconstruction

Full-mouth reconstruction to change the occlusion or vertical dimension

An obturator to correct a defect, such a cleft palate

Implant placements provided more than once per tooth in the member’s lifetime

Separate payments for abutment placement or substitution for the removal of a temporary healing cap. Payment for these services is embedded in the payment for the endosteal implant and will not be paid separately

Eposteal implants, tranostelas implants and all other types of implants

Surgical procedures to correct birth defects or develop-mental malformations such as clef palate and jaw malformations

Periodontal surgical barriers and guided tissue regeneration or periodontal splinting of any type

Drugs and medications not dispensed by the dentist and those available without a prescription or used in connection with noncovered services

Replacement of lost, missing or stolen restorations, appliances or prosthetics

Treatment for injuries to the mouth as a result of an accident

Services covered under your medical coverage, which may include, but are not limited to:

- Surgery and diagnostic services
- General anesthesia and intravenous sedation in conjunction with billable procedures only when medically necessary and performed in a hospital setting
- Excisional or incisional biopsy of oral lesions
- Prosthetic appliances
- Treatment of temporomandibular joint syndrome (TMJ) and jaw joint disorders
- Treatment of injuries, broken teeth and bone as a result of an accident to the lower half of the face or jaw
Section 6. Blue Vision Coverage

Blue Vision℠ Coverage – Active Participants, Pre-Medicare & Post Medicare Participants

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call 1-800-877-7195 or log on to the VSP Web site at vsp.com.

**Note:** Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

<table>
<thead>
<tr>
<th>Eye care wellness</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete eye exam by an ophthalmologist or optometrist</td>
<td>20% discount off a thorough eye exam</td>
<td>No discount available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription eyewear discounts</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard lenses and standard frames</td>
<td>20% discount off unlimited complete pairs of prescription glasses and non-prescription sunglasses – one pair of lenses, with or without frames, in any period of 12 consecutive months</td>
<td>No discount available</td>
</tr>
<tr>
<td>Lens options</td>
<td>20% discount off all lens options</td>
<td>No discount available</td>
</tr>
<tr>
<td>Contact lens evaluation and fitting</td>
<td>15% discount off contact lens services (discount does not apply to eyewear)</td>
<td>No discount available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laser Vision Care program</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laser surgery including PRK, LASIK, and Custom Lasik – must be VSP contracted Laser center</td>
<td>VSP has contracted with many of the nation’s finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP’s Web site at vsp.com to learn more about this exciting program</td>
<td>No discount available</td>
</tr>
</tbody>
</table>
## Vision Benefits Not Covered

Additional charges for:
- Lenses tinted darker than Rose tint #2 (such as sunglasses)
- Oversize lenses (61 mm and larger)
- Blended lenses
- Photochromic lenses
- Progressive/multifocal lenses
- Coating/laminating of a lens or lenses
- Cosmetic lenses/processes
- Two pair of glasses instead of bifocals
- Antireflective lenses
Section 7. Schedule of Benefits for Pre-Medicare Participant Benefits

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM’s approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: To be eligible for coverage, the following services require your provider to obtain approval before they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – Select specialty pharmaceuticals do not require preauthorization.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Eligibility Information

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
</table>
| Dependents | □ Subscriber’s legal spouse  
 | □ **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the **last day of the month** the dependent turns age 26 |

No-fault motor vehicle accidents | Coverage is excluded for all services related to an injury which is a direct or indirect result of any motor vehicle accident, including but not limited to automobiles, motorcycles, buses, and trucks. This applies whether or not the individual has no-fault insurance. Please see page ninety-five (95) for the complete exclusion |
Comprehensive Major Medical

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

**Note:** If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between BCBSM’s approved amount and the provider’s charge.

<table>
<thead>
<tr>
<th>Annual Out-of-Pocket Maximums</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>(These amounts may change annually)</td>
<td>$6,350 Individual/$12,700 Family</td>
</tr>
<tr>
<td>This is the maximum amount you’ll have to pay each year for covered medical services. This includes coinsurance and fixed dollar copays.</td>
<td>(Does not count Towards Out-of-Network, Out-of-Pocket Maximums)</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>$6,350 Individual/$12,700 Family</td>
</tr>
<tr>
<td>(Does not count Towards In-Network, Out-of-Pocket Maximums)</td>
<td></td>
</tr>
</tbody>
</table>

**Deductibles**

- None

**Fixed dollar copays**

- $20 copay for select office visits

**Percent copays**

- 20% of approved amount for most covered services

**Annual copay dollar maximums** – excludes fixed dollar copays and private duty nursing percent copays

- $1,200 per contract each calendar year

**Lifetime dollar maximum**

- None

**Preventive care services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Gynecological exam</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Pap smear screening – laboratory and pathology services</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Voluntary sterilizations for females</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician</td>
<td>100% (no copay)</td>
</tr>
<tr>
<td>Contraceptive injections</td>
<td>100% (no copay)</td>
</tr>
<tr>
<td>Well-baby and child care visits</td>
<td>100% (no copay)</td>
</tr>
<tr>
<td>- 6 visits, birth through 12 months</td>
<td></td>
</tr>
<tr>
<td>- 6 visits, 13 months through 23 months</td>
<td></td>
</tr>
<tr>
<td>- 6 visits, 24 months through 35 months</td>
<td></td>
</tr>
<tr>
<td>- 2 visits, 36 months through 47 months</td>
<td></td>
</tr>
<tr>
<td>- Visits beyond 47 months are limited to one per individual per calendar year under the health maintenance exam benefit</td>
<td></td>
</tr>
</tbody>
</table>
### Summary Plan Description

<table>
<thead>
<tr>
<th>Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act</th>
<th>100% (no copay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecal occult blood screening</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy exam</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) screening</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Screening CA-125 tests</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Routine mammogram and related reading</td>
<td>100% (no copay), one per individual per calendar year</td>
</tr>
<tr>
<td>Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy – routine or medically necessary</td>
<td>100% (no copay) for the first billed colonoscopy, one per individual per calendar year</td>
</tr>
<tr>
<td>Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.</td>
<td></td>
</tr>
</tbody>
</table>

### Physician office services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay per office visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
<td>$20</td>
</tr>
<tr>
<td>Outpatient and home medical care visits</td>
<td>$20</td>
</tr>
<tr>
<td>Office consultations</td>
<td>$20</td>
</tr>
<tr>
<td>Urgent care visits</td>
<td>$20</td>
</tr>
</tbody>
</table>

### Physician and other professional benefits not covered

- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan
- 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
- Health care services provided by persons who are not legally qualified or licensed to provide them
- Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization), unless otherwise noted as an included benefit
- Artificial and endodontic dental implants and related services, including repair and maintenance of implants
and surrounding tissue, unless otherwise noted as an included benefit

Weight loss programs

Contraceptive devices and medications used for the express purpose of preventing pregnancy, unless otherwise noted as an included benefit

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

Services, care, supplies or devices not prescribed by a physician

Services provided during nonemergency medical transport

Experimental treatment

Hearing aids or services to examine, prepare, fit or obtain hearing aids, unless otherwise noted as an included benefit

Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens

Hospital services, including services provided by hospital employees

Drugs, medical appliances, materials or supplies or blood transfusions

Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, except for:

- Surgery directly to the temporomandibular joint (jaw joint)
- Diagnostic X-rays
- Arthrocentesis
- Physical therapy

Note: The above restriction applies to any condition causing the temporomandibular joint (jaw joint) dysfunction

Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)

Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient’s endurance while exercising and management of risk factors are stable

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 us to determine if other proposed services are a covered benefit under your Certificate.

Sports medicine, pain management, patient education (except as otherwise specified) or home exercise programs

Screening services (except as otherwise stated)

Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under your Certificate

Those available in a hospital maintained by the state or federal government, unless payment is required by law

Those payable by government, sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services is payable if federal laws require the government, sponsored program to
Emergency medical care

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Physician’s office</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

Diagnostic services

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and pathology services</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Diagnostic tests and x-rays</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Therapeutic radiology</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

Maternity services provided by a physician or certified nurse midwife

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>Delivery and nursery care</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

Hospital care

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies, unlimited days</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td><strong>Note</strong>: Nonemergency services must be rendered in a participating hospital.</td>
<td></td>
</tr>
<tr>
<td>Inpatient consultations</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

Alternatives to hospital care

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing care – must be in a participating skilled nursing facility</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Hospice care</td>
<td>100% (no copay), up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)</td>
</tr>
<tr>
<td>Home health care – must be medically necessary and provided by a participating home health care agency</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers | 80% of approved amount

**Inpatient hospital benefits not covered**
Services that may be medically necessary but can be provided safely in an outpatient or office location; except when noted by other benefit coverage
Services of physicians and surgeons not employed by the hospital
Custodial care or rest therapy
Psychological tests if used as part of, or in connection with, vocational guidance training or counseling

**Dental services.** However, certain procedures may be payable as medical services if performed in a hospital because the patient has a dental condition that is adversely affecting a medical condition such as:

- Bleeding or clotting abnormalities
- Unstable angina
- Severe respiratory disease
- Known reaction to analgesics, anesthetics, etc.

- Those procedures include:
  - Alveoplasty
  - Diagnostic X-rays
  - Multiple extractions or removal of unerupted teeth
  - Gingivectomy

**Note:** Medical records must verify the patient’s concurrent hazardous medical condition.

**Services covered under any other Blue Cross Blue Shield contract or under any health care benefits plan**

**Screening services**
Artificial and endodontic transplants and related services, including repair and maintenance of implants and surrounding tissue

Those for care that is not considered acute, such as:

- Observation
- Dental treatment, including extraction of teeth, except as otherwise noted in this Certificate
- Diagnostic evaluations
- Lab exams
- Electrocardiography
- Weight reduction
- X-ray, exams or therapy
- Cobalt or ultrasound studies
- Basal metabolism tests
- Convalescence or rest care
- Convenience items

Those mainly for physical therapy, speech and language pathology services or occupational therapy; except when noted by other benefit coverage
<table>
<thead>
<tr>
<th>Surgical services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery – includes related surgical services</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td><strong>Note:</strong> BCBSM will pay for medically necessary facility services only by a BCBSM participating ambulatory surgery facility.</td>
<td></td>
</tr>
<tr>
<td>Presurgical consultations</td>
<td>$20 copay per visit</td>
</tr>
<tr>
<td>Voluntary sterilization for males</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td><strong>Note:</strong> See “Preventive care services” section for voluntary sterilizations for females.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Human organ transplants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</td>
<td>100% (no copay) – in designated facilities only</td>
</tr>
<tr>
<td>Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Specified oncology clinical trials</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Kidney, cornea and skin transplants</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health care and substance abuse treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health care</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Inpatient substance abuse treatment</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Outpatient mental health care</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Outpatient substance abuse treatment</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Autism spectrum disorders, diagnoses and treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied behavioral analyses (ABA) treatment – limited to an annual maximum of $50,000 per member, through age 18 (limits may be waived on an individual consideration basis)</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder – through age 18</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Other covered services, including mental health services, for Autism Spectrum Disorder</td>
<td>80% of approved amount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other covered services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Diabetes Management Program (ODMP)</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a participating provider</td>
<td></td>
</tr>
<tr>
<td>• 100% (no copay) for diabetes self-management training by a participating provider</td>
<td></td>
</tr>
<tr>
<td>• 80% of approved amount for diabetes</td>
<td></td>
</tr>
</tbody>
</table>
network provider. | medical supplies
---|---
Allergy testing and therapy | 80% of approved amount
Chiropractic spinal manipulation | $20 copay per visit, limited to a maximum of 27 visits per individual per calendar year
Outpatient physical, speech and occupational therapy | 80% of approved amount
Durable medical equipment
**Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider. | 80% of approved amount
Prosthetic and orthotic appliances | 80% of approved amount
Private duty nursing | 80% of approved amount
Nail debridement | 80% of approved amount

**Dental Benefits**

An explanation of dental benefits can be found in Section 5 pages 79 through 82.

Dental benefits are only available to Retired participants that elect to remit the self-payments required by the Fund to obtain dental benefits.

**Vision Benefits**

An explanation of the VSP discounts available to Retirees can be found in Section 6 pages 83 through 84.

The following services are excluded and are Non-Payable:

**Hospital and Facility Care Inpatient Services Non-Payable:**

| Services received in a non-participating hospital or facility. |
| Services that may be medically necessary but can be provided safely in an outpatient of office location. |
| Custodial care or rest therapy. |
| Psychological tests if used as part of, or in connection with, vocational guidance training or counseling. |
| Human organ transplants except for the following: kidney, cornea, skin bone marrow, combined small intestine-liver, heart, heart-lung(s), liver, lobar lung, lung(s), pancreas, partial liver, kidney-liver, simultaneous pancreas-kidney, small intestine (small bowel), multivisceral transplants (as determined by BCBSM). |
| Dental services except as follows: Facility and anesthesia services may be payable if a hospitalized patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. In these cases, services are covered for the facility and anesthesia services only, not for the services of a dentist or other dental professional. |
| Screening services while in-patient. |
| Services covered under any other Blue Cross or Blue Shield contract or under any health care benefits plan except for Coordination of Benefits. |
| Dental implants and related services, including repair and maintenance of implants and surrounding tissue. |
Non-contractual services through case management treatment plans when such services have not been approved by BCBSM.

| Coverage is excluded for all services related to an injury which is a direct or indirect result of any motor vehicle accident, including but not limited to automobiles, motorcycles, buses, and trucks. This applies whether or not the individual has no-fault insurance. Please see page ninety-five (95) for the complete exclusion |
| No-fault motor vehicle accidents |

**Hospital admissions that are not covered by the BCBSM certificate as follows:**

- Care that is not considered acute such as:
  - Observation
  - Dental treatment, including extraction of teeth except as noted above
  - Diagnostic evaluations
  - Lab exams
  - Electrocardiography
  - Weight reduction
  - X-rays, exams or therapy
  - Cobalt or ultrasound studies
  - Basal metabolism tests
  - Convalescence or rest care
  - Convenience care
  - Hospital Services mainly for physical therapy, speech and language pathology services or occupational therapy

**Hospital and Facility Care Outpatient Services Non-Payable:**

- Services for mental health care that is beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient’s condition according to generally accepted professional standards or in a skilled nursing facility.
- Services in a non-participating ambulatory surgery facility.
- Services provided by a non-participating end stage renal disease facility.
- Services not provided by the employees of an end stage renal disease facility.
- Services not related to end stage renal disease dialysis processes.
- Home Health Care Services Non-Payable are: general housekeeping services, transportation to and from a hospital or other facility, custodial care or non-skilled care, services performed by a non-participating home health care provider.

**Other Non-Payable Providers:**

- Non-participating hospitals (except for emergency services at an accredited non-participating hospital), facilities or alternative to hospital care providers. Emergency services are paid at BCBSM’s approved amounts.
- Services at non-participating --- outpatient physical therapy facilities, freestanding ambulatory surgery facilities, mental health or substance abuse treatment facilities, skilled nursing facilities, hospice programs, home health care agencies, infusion therapy providers.

**Other Non-Payable Services:**

- Services that are covered by any other BCBSM certificate or under any other health care benefits plan except
Physician Services Non-Payable:

- Services for cosmetic surgery when performed solely to improve appearance.
- Services provided by persons who are not eligible for payment or appropriately credentialed or legally authorized or licensed to order or provide such services.
- Dental care except to treat an accidental injury or if an inpatient due to a medical necessity.
- Pre-employment, pre-marital, school and sports physicals unless needed to diagnose or treat a specific disease, illness, pregnancy or injury.
- Weight loss programs.
- Services in a non-hospital institution except for approved home health care.
- Services, care, supplies or devices not prescribed by a physician.
- Non-contractual services described through a case management treatment plan not approved by BCBSM.
- Services provided during non-emergency medical transport.
- Experimental treatment.
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient’s condition according to generally accepted professional standards.
- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances unless you lack a natural lens.
- Irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction except for surgery directly to the temporomandibular joint and related anesthesia services, diagnostic x-rays, arthrocentesis, approved physical therapy.
- Self-treatment by a professional provider and services given to parents, siblings, spouse or children.
- Alternative medicines or therapies such as acupuncture, herbal medicines and massage therapy.
- Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient’s endurance while exercising and management of risk factors are stable.
- Infertility services that do not treat a medical condition other than infertility 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.
- Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue, unless otherwise noted as an included benefit.
- Rest therapy or services provided while in a convalescent home, long term care facility, nursing home, rest home or similar non-hospital institution.
- Sports medicine, pain management, patient education (except as otherwise specified) or home exercise programs.
- Screening services (except as otherwise stated).
- Services for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under your Certificate.
- Services available in a hospital maintained by the state or federal government, unless payment is required by law.
- Services payable by government-sponsored health care programs such as Medicare, for which a member is eligible. These services are Non-Payable even if you have not signed up to receive the benefits provided by such programs.
programs. However, care and services are payable if federal law requires the government-sponsored program to be secondary to this coverage.

Services not listed in your Certificate as being payable.

<table>
<thead>
<tr>
<th>Devices and Services Non-Payable:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-rigid devices and supplies such as elastic stockings, garter belts, arch supports and corsets.</td>
</tr>
<tr>
<td>Spare prosthetic devices.</td>
</tr>
<tr>
<td>Routine maintenance of the prosthetic device.</td>
</tr>
<tr>
<td>Prosthetic devices that are experimental.</td>
</tr>
<tr>
<td>Hair prostheses such as wigs, hair pieces, hair implants, etc.</td>
</tr>
<tr>
<td>Hearing aids or services to examine, prepare, fit or obtain hearing aids.</td>
</tr>
</tbody>
</table>

**No-Fault Auto Insurance**

If you or an eligible dependent are involved in a motor vehicle accident, Michigan Laborers’ Health Care Fund will not pay for services related to an injury which is a direct or indirect result of an automobile accident. This applies whether or not you have no-fault automobile insurance.

In addition, the Michigan Laborers’ Health Care Fund will be secondary to motorcycle insurance when services are provided to treat an injury or condition that is a result of a motorcycle accident that is not a motor vehicle accident when the Member carries or is required to carry motorcycle insurance, regardless of whether a helmet was worn by the driver and/or passenger. In no event will benefits be covered for an injury or condition of a Member who rides without a helmet and is injured in a non-motor vehicle accident until after the first $20,000 of expenses is paid by the motorcycle insurance carrier with respect to Member riders who are required by Public Act 98 to carry motorcycle insurance.

If such Member does not carry the required insurance and the Member is injured while riding a motorcycle in an accident that is not a motor vehicle accident, then the Member's claims arising out of that accident are completely excluded. Payments for services to any provider made prior to discovery by BCBSM or the group health plan that the services arose as a result of the Member’s injury in a motorcycle accident that is not a motor vehicle accident for which insurance is carried or required to be carried will be recovered from the provider(s). Payment for these services would then become the member’s responsibility or the responsibility of the member’s motorcycle insurance carrier.
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Section 8. Medicare Coverage for Eligible Members

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

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

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

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

**Employed Persons Age sixty-five (65) or Older**

When you reach sixty-five (65) and become eligible for Medicare, but are still eligible through a Fund of twenty (20) or more persons, you have two options for health care coverage. You may:

1. Continue your regular current coverage as your primary health care plan *(Option 1)* or
2. Select Medicare as your primary health care plan *(Option 2)*

The following explains these options:

- **Option 1** – You may continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue this coverage.

**Important:** If you continue to be covered through your Fund as an active participant for your primary health care benefits, you should still apply for Medicare benefits, Part A. Remember:

- Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide additional benefits to your group coverage.
Part B of Medicare, the medical insurance, is available for a monthly premium. * However, you can delay enrollment in Part B without penalty if you are an active member through the Michigan Laborers’ Health Care Fund.

Part D of Medicare, the prescription drug coverage, is available for a monthly premium. If you do enroll in the Medicare Part D prescription drug coverage, your coverage through the Fund will be terminated.

If you are an active participant you are required to enroll in part A of Medicare when you become eligible for Medicare. You should immediately forward a copy of your Medicare Card to the Fund Office. You are not required to enroll in the Medicare Part D Prescription Drug program.

Because the current prescription drug benefit offered to you through the Michigan Laborers’ Health Care Fund is as good as or better than that available under a Medicare prescription drug plan, the Trustees have decided to continue the current prescription drug coverage for retirees. It is therefore imperative that you do not enroll in the Medicare Part D Prescription Drug Program. If you do enroll in the Medicare Part D prescription drug coverage, your coverage through the Fund will be terminated.

- If you are an active eligible participant and you delayed enrolling in Medicare Part B coverage when you reach sixty-five (65), you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your group plan and ends two months later.

**Option 2** – You may select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibit your Fund from providing you with Supplemental coverage. You must file a written notice with your Fund Office, with Medicare and with BCBSM if you choose this option.

*Reminder:* If you have a spouse who is sixty-five (65) or older and is covered under your group plan, your Fund must provide the same coverage you select to your spouse until you retire or leave employment.
How Your BCBSM Supplemental Coverage Works

Your BCBSM Supplemental coverage is designed to ensure you receive the same level of health care coverage as those active members. However, because you also have Medicare coverage, your Supplemental coverage is coordinated as follows:

- If Medicare covers a service, then Medicare is considered the primary carrier and pays the claim first. Then, as your secondary carrier, BCBSM covers any Medicare Part A or B deductibles and coinsurance amounts if the service is a benefit under your BCBSM Supplemental plan, subject to BCBSM copayments.

  Note: If Medicare covers the service in full, then your Supplemental coverage has no responsibility for the claim except if Medicare denies the claim.

- If the service is not covered by Medicare, but covered under your Supplemental plan, then BCBSM is considered the primary carrier and pays the claim less your copayment.

Always give your Medicare and BCBSM ID cards to your health care provider. This insures that both Medicare and BCBSM review your claims for payment.

All benefits covered and paid by BCBSM, either as the primary or secondary carrier, are subject to applicable copayments and any benefit limitations and dollar maximums outlined in this booklet.

BCBSM Supplemental Benefits

Your BCBSM Supplemental coverage ensures you receive the same level of health care coverage as those members with active coverage provided you are eligible for Medicare Parts A & B. The BCBSM Supplemental payment will be determined as follows:

Medical Coverage

Your Supplemental coverage, in combination with Medicare, provides the same benefits that are described in this booklet for active members. All benefits will be coordinated as described under “How Your BCBSM Supplemental Coverage Works.”
Other Coverage

If your health care plan also includes prescription drugs, dental, vision and/or hearing benefits for active members, then your BCBSM Supplemental coverage, in combination with Medicare, provides the same benefits described in this booklet. Applicable copayments, dollar maximums and benefit limits apply.

Because the Fund provides prescription drug coverage that is equivalent or better than the coverage offered through the Medicare Part D program, you should not enroll in the Medicare Part D program. Please contact the Fund Office for further information.

Eligibility Information

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependents</td>
<td>❖ Subscriber’s legal spouse</td>
</tr>
<tr>
<td></td>
<td>❖ <strong>Dependent children</strong>: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26</td>
</tr>
<tr>
<td>No-fault automobile accidents</td>
<td>Coverage is excluded for all services related to an injury which is a direct or indirect result of any motor vehicle accident, including but not limited to automobiles, motorcycles, buses, and trucks. This applies whether or not the individual has no-fault insurance.</td>
</tr>
</tbody>
</table>

Medicare Supplemental Coverage

**Michigan Laborers’ Health Care Fund – Medicare Supplemental Benefit Summary**

The information contained herein provides a general summary of your group’s health care benefits. It is not a contract. This summary may not reflect additional limitations or exclusions that apply to covered services or the most recent updates to BCBSM certificates, riders, plan modifications and/or changes that your group may be making to your coverage. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. You can also contact your health care administrator or call the customer service phone number printed on the back of your ID card if you have additional questions regarding your health care benefits.

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at medicare.gov or at any Social Security office).
Medicare Supplemental Coverage is provided to Medicare enrollees who have both Medicare Part A and Part B coverage. Your Plan coverage in combination with Medicare, allows the same level of benefits for Medicare enrollees as provided to members not enrolled in the Medicare program. BCBSM will pay for covered services described in your certificate, minus those amounts payable by Medicare, and minus any applicable coinsurance/copayment required by your Plan. If a service is not covered by Medicare, but it is a benefit under the Plan, payment is based on the BCBSM approved amount minus any applicable coinsurance/copayment required by your Plan.

You are required to enroll in both parts A and B of Medicare when you become eligible for Medicare. You should immediately forward a copy of your Medicare Card to the Fund Office. You are not required to enroll in the Medicare Part D Prescription Drug program.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible amounts</td>
<td>• Medicare Part A $1,184* (for days 1-60) each benefit period</td>
<td>20% of Medicare Part A Deductible/Medicare Balances</td>
</tr>
<tr>
<td></td>
<td>• Medicare Part B $147* per calendar year</td>
<td>20% of Medicare Part B Deductible/Medicare Balances</td>
</tr>
<tr>
<td>Fixed dollar copays</td>
<td>• Hospitalization $296* per day (for days 61-90) and $592* per day (for days 91-150)</td>
<td>20% of Medicare Balance</td>
</tr>
<tr>
<td></td>
<td>• Skilled nursing facility care (a limit of 100 days for each benefit period)</td>
<td>20% of Medicare Balance</td>
</tr>
<tr>
<td></td>
<td>$148* per day (for days 21-100)</td>
<td>up to annual coinsurance maximum of $1,200 Individual or Family. (Your coinsurance maximum begins each January 1 through December 31.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$20 Copayment for office visits, urgent care visits, chiropractic visits</td>
</tr>
<tr>
<td>Coinsurance/percent copay amounts</td>
<td>• 20% of Medicare approved amount for most general services</td>
<td>20% of Medicare Balances up to annual coinsurance maximum of $1,200 Individual or Family. (Your coinsurance maximum begins each January 1 through December 31.)</td>
</tr>
<tr>
<td></td>
<td>• 35%* of Medicare approved amount for outpatient mental health care</td>
<td>$20 Copayment for office visits, urgent care visits, chiropractic visits</td>
</tr>
<tr>
<td></td>
<td>• 50% of Medicare approved amount for outpatient substance abuse</td>
<td></td>
</tr>
</tbody>
</table>
## Preventive care services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>What Medicare coverage pays</th>
<th>What Supplemental coverage pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health maintenance exam</td>
<td>Covered at 100% of Medicare approved amount**, once every 12 months</td>
<td>Covered in full by Medicare; no additional coverage by BCBSM</td>
</tr>
<tr>
<td><strong>Note:</strong> Your first yearly “Wellness” exam can’t take place within 12 months of your “Welcome to Medicare” physical exam.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecological exam</td>
<td>Covered at 100% of Medicare approved amount**, once every 24 months</td>
<td>When not covered by Medicare – covered at 80% of BCBSM approved amount, one per member per calendar year</td>
</tr>
<tr>
<td>Pap smear screening – laboratory services only</td>
<td>Covered at 100% of Medicare approved amount**, once every 24 months (more frequently if at high risk)</td>
<td>When not covered by Medicare – covered at 80% of BCBSM approved amount, one per member per calendar year</td>
</tr>
<tr>
<td>Voluntary sterilizations for females</td>
<td>Not covered</td>
<td>Covered at 100% of BCBSM approved amount in-network</td>
</tr>
<tr>
<td><strong>Note:</strong> Medicare covers voluntary sterilization if it’s necessary for the treatment of an illness of injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician</td>
<td>Not covered</td>
<td>Covered at 100% of BCBSM approved amount</td>
</tr>
<tr>
<td>Contraceptive injections – includes cost of medication when provided by the physician</td>
<td>Not covered</td>
<td>Covered at 100% of BCBSM approved amount</td>
</tr>
<tr>
<td>Fecal occult blood test</td>
<td>Covered at 100% of Medicare approved amount**, once every 12 months, if age 50 and older</td>
<td>When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy exam</td>
<td>Covered at 100% of Medicare approved amount**, once every 48 months, if age 50 and older</td>
<td>When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage Details</td>
<td>Additional Coverage Details</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) test</td>
<td>Covered at 100% of Medicare approved amount**, once every 12 months, if over age 50</td>
<td>When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year</td>
</tr>
<tr>
<td>Flu shots</td>
<td>Covered at 100% of Medicare approved amount**, once per flu season in the fall or winter</td>
<td>Covered in full by Medicare; no additional coverage by BCBSM</td>
</tr>
<tr>
<td>Hepatitis B shots – for those at high or medium risk of contracting the disease</td>
<td>Covered at 100% of Medicare approved amount**</td>
<td>Covered in full by Medicare; no additional coverage by BCBSM</td>
</tr>
<tr>
<td>Pneumococcal shot</td>
<td>Covered at 100% of Medicare approved amount**</td>
<td>Covered in full by Medicare; no additional coverage by BCBSM</td>
</tr>
<tr>
<td>Mammography screening</td>
<td>Covered at 100% of Medicare approved amount**, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)</td>
<td>When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Covered at 100% of Medicare approved amount**, once every 10 years (if at high risk every 24 months)</td>
<td>When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year</td>
</tr>
<tr>
<td>Well-baby and child care visits</td>
<td>One health maintenance exam covered at 100% of Medicare approved amount** every 12 months, subsequent well-baby and child care visits not covered</td>
<td>Covered at 100% of BCBSM approved amount • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</td>
</tr>
</tbody>
</table>
### Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act and not covered by Medicare

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not covered</td>
<td>Covered at 100% of BCBSM approved amount</td>
<td>Covers Medicare Balance after $20 Copayment</td>
</tr>
</tbody>
</table>

### Physician office services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers Medicare Balance after $20 Copayment</td>
</tr>
<tr>
<td>Outpatient and home visits</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers Medicare Balance after $20 Copayment</td>
</tr>
<tr>
<td>Office consultations</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers Medicare Balance after $20 Copayment</td>
</tr>
</tbody>
</table>

### Emergency medical care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room (facility services) – must be medically necessary</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
<tr>
<td>Ambulance services – must be medically necessary</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
</tbody>
</table>

### Clinical laboratory services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and pathology tests – used in the diagnosis and treatment of an illness or injury</td>
<td>Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
</tbody>
</table>
### Hospital care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies</td>
<td>Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance abuse)</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
<tr>
<td>• Days 1-60</td>
<td>Covered at 100% of Medicare approved amount less Part A deductible</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
<tr>
<td>• Days 61-90</td>
<td>Covered at 100% of Medicare approved amount less Part A daily coinsurance</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
<tr>
<td>• Lifetime reserve days (60 days)</td>
<td>Covered at 100% of Medicare approved amount less Part A daily coinsurance</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
<tr>
<td>• Additional days</td>
<td>Not covered</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria</td>
<td>Covers 80% of Medicare Balance; pays chemotherapy drugs which Medicare does not cover; must meet BCBSM criteria for payment</td>
</tr>
</tbody>
</table>

### Alternatives to hospital care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility care – specific criteria applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Days 1-20</td>
<td>Covered at 100% of Medicare approved amount</td>
<td>Covered in full by Medicare</td>
</tr>
<tr>
<td>• Days 21-100</td>
<td>Covered at 100% of Medicare approved amount less daily coinsurance</td>
<td>Covers 80% of Medicare Balance</td>
</tr>
<tr>
<td>• Days 101 and after</td>
<td>Not covered</td>
<td>Covered @ 80%; must meet BCBSM criteria</td>
</tr>
<tr>
<td>Hospice care</td>
<td>Covered at Medicare approved amount less small copayment for outpatient drugs and less small coinsurance for inpatient respite care</td>
<td>Covers limited costs not covered by Medicare</td>
</tr>
<tr>
<td>Home health care services – must be medically necessary</td>
<td>Covered at 100% of Medicare approved amount</td>
<td>Covered in full by Medicare</td>
</tr>
</tbody>
</table>
### Surgical services provided by a physician

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery – includes related surgical services</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers 80% of Medicare deductible and coinsurance</td>
</tr>
</tbody>
</table>

### Human organ transplants

**Note:** Payment is based on medical necessity and must be rendered in an approved facility.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart and liver transplants</td>
<td>Covered at 80% of Medicare approved amount less deductible</td>
<td>Covers Medicare deductible and coinsurance</td>
</tr>
<tr>
<td>Lung and heart-lung transplants</td>
<td>Covered at 80% of Medicare approved amount less deductible</td>
<td>Covers Medicare deductible and coinsurance</td>
</tr>
<tr>
<td>Pancreas transplants</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Bone marrow transplants – under certain conditions</td>
<td>Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)</td>
<td>Covers 80% of Medicare deductible and coinsurance</td>
</tr>
<tr>
<td>Kidney, cornea and skin transplants</td>
<td>Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)</td>
<td>Covers 80% of Medicare deductible and coinsurance</td>
</tr>
</tbody>
</table>

*Note:* Pancreas transplants are covered under certain conditions. Please call Medicare for more information.
### Mental health care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong> mental health care in psychiatric facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Days 1-190 lifetime</td>
<td>See “Hospital care” benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance)</td>
<td>Covers 80% of Medicare deductible and coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.</td>
<td></td>
</tr>
<tr>
<td>• Additional days after 190 lifetime days are used</td>
<td>Not covered</td>
<td>Covers 80%; must meet BCBSM criteria</td>
</tr>
<tr>
<td><strong>Outpatient</strong> mental health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered at 65% of Medicare approved amount less Part B deductible</td>
<td>Covers 80% of Medicare deductible and coinsurance</td>
</tr>
<tr>
<td></td>
<td>(Diagnostic services are covered at 80% of Medicare approved amount less Part B deductible)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.</td>
<td></td>
</tr>
</tbody>
</table>

### Other covered services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy testing and therapy – with approved diagnosis</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers 80% of Medicare deductible and coinsurance for testing. Injections covered @ 80% of BCBSM approved amount.</td>
</tr>
<tr>
<td>Chiropractic spinal manipulation – must be medically necessary</td>
<td>Covered at 80% of Medicare approved amount less Part B deductible</td>
<td>Covers Medicare Balance after $20 Copayment</td>
</tr>
</tbody>
</table>
### Outpatient physical, speech and occupational therapy
- Covered at 80% of Medicare approved amount less Part B deductible
- **Note:** There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.
- Covers 80% of Medicare deductible and coinsurance or set copayment

### Durable medical equipment
- Covered at 80% of Medicare approved amount less Part B deductible
- Covers 80% of Medicare deductible and coinsurance

### Prosthetic appliances
- Covered at 80% of Medicare approved amount less Part B deductible
- Covers 80% of Medicare deductible and coinsurance

### Private duty nursing
- Not covered
- Covered @ 80% of BCBSM approved amount; must meet BCBSM medical criteria

### Oral cancer drugs
- Approved drugs are covered
- Covered in full by Medicare

### Foreign travel

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicare coverage</th>
<th>Supplemental coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital services</td>
<td>Not covered, except as specified in the Medicare handbook</td>
<td>Covered at BCBSM approved amount, must meet BCBSM criteria</td>
</tr>
<tr>
<td>Physician services</td>
<td>Not covered, except as specified in the Medicare handbook</td>
<td>Covered at BCBSM approved amount, must meet BCBSM criteria</td>
</tr>
</tbody>
</table>

### Dental Benefits

An explanation of dental benefits can be found in Section 5 pages 79 through 82.

Dental benefits are only available to Retired participants that elect to remit the self-payment required by the Fund to obtain dental benefits.

### Vision Benefits

An explanation of the VSP discounts available to Retirees can be found in Section 6 pages 83 through 84.
Section 9. Your Right to Request Review of an Adverse Benefit Determination

Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved through a phone call to one of BCBSM’s Customer Service Representatives. You can locate the phone number in the top right hand corner of the first page of your Explanation of Benefits statement or in the letter BCBSM sends to notify you that BCBSM has not approved a request for benefits.

In addition, the Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations protect you by providing you the opportunity to request review of an adverse benefit determination. An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in your employer’s health plan. An adverse benefit determination also includes a rescission of coverage. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

“Pre-service claim” means a claim for a benefit where your plan conditions receipt of the benefit, in whole or in part, on obtaining approval in advance of receiving medical care.

“Urgent care claim” means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function. An urgent care claim can also be made when, or in the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care if a physician with knowledge of your medical condition determines the claim is one involving urgent care. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, BCBSM will treat it as such. Absent a determination by your physician, BCBSM will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

“Post-service claim” means all other claims that are not “pre-service claims” or “urgent care claims.”

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing. Normally, for all three types of claims, you must exhaust applicable review procedures before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.
Review Procedure

A. Review Procedure – Post-service claims

Under the review procedure for post-service claims, you are entitled to a two step appeal process. BCBSM will provide you with a written determination within sixty (60) calendar days of BCBSM’s receipt of your written requests for review at each level.

The review procedure for post-service claims provides two levels of review:

1. To initiate an internal review, you or your authorized representative must send BCBSM a written statement explaining why you disagree with their determination. Please include in your request all documentation, records or comments you believe support your position. You can also include notarized statements, declarations or testimony but these are not required. You must request review no later than one hundred eighty (180) calendar days after you receive BCBSM’s decision on your claim for benefits. Mail your written request for review to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter BCBSM sends you to notify you that BCBSM has not approved a benefit or service you are requesting. BCBSM will respond to your request for review in writing within thirty (30) days. If you agree with BCBSM’s response, it becomes their final determination and the review ends.

2. If you disagree with BCBSM’s response to your request for review. You must request review in writing no later than thirty (30) calendar days after you receive BCBSM’s determination.

Mail your request to the address specified in the letter BCBSM sends you to notify you BCBSM has not approved your appeal at level one (1).

Again, please provide all documentation, records, and comments that you feel support your position. And, you can also include notarized statements, declarations or testimony although these are not required. You will receive a written determination of your request by the latter of (a) the Plan’s next regularly scheduled meeting which is at least 30 days after the date of your level one (1) request or (b) thirty (30) days following your request for review unless the Trustees tell you that they need more time.

3. If you disagree with the final determination, or if the determination at each level is not issued within the thirty (30) day time frame or the review procedures are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

B. Review Procedure – Pre-service claims

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

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

C. Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

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

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

3. If you disagree with the final determination, or if you fail to receive a final determination within seventy-two (72) hours, or otherwise fail to receive a reply that complies with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims:

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

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

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

d. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
e. You may submit notarized statements, written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.

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

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

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

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

j. If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion without charge upon request.

k. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment without charge upon request.

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

Have Questions? Call 877-258-3932
Section 10. Burial and Accidental Death and Dismemberment Benefits

The following information explains the burial and accidental death and dismemberment benefits available to you.

Burial Benefits

Burial benefits apply to those persons who are eligible by employer contributions, disability hours, retiree or active self-payments on the date of death (Surviving spouse self-payments do not provide death benefits). Burial benefits are payable in the following amounts:

- Participant – five thousand dollars ($5,000)
- Spouse – two thousand dollars ($2,000)
- Dependent Child – two thousand dollars ($2,000)

Written notice of the death must be given to the Fund Office within one (1) year of the date of death, otherwise no benefits will be payable. No burial benefits are payable if the death of the covered person is the result of felonious activity or aggravated assault.

Accidental Death and Dismemberment Benefits (Active Member)

If you are injured through external, violent or accidental means, on or off the job, while you are eligible for benefits by either employer contributions, active self-payments or disability hours, and the injury causes one of the following losses, the Plan will pay benefits for the losses according to the following schedule:

<table>
<thead>
<tr>
<th>LOSS OF:</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$5,000</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>$5,000</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>$5,000</td>
</tr>
<tr>
<td>One hand or one foot &amp; entire sight of one eye</td>
<td>$5,000</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>$2,500</td>
</tr>
<tr>
<td>Entire sight of one eye</td>
<td>$2,500</td>
</tr>
<tr>
<td>Entire sight of both eyes</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

With reference to hand or foot, “loss” means complete severance through or above the wrist or ankle joint and with reference to eye, means the irrecoverable loss of the entire sight of the eye. Benefits will not be paid for more than one (1) of the losses (the greatest) sustained by the employee as the result of any one (1) accident.

No accidental death and dismemberment benefits are payable if the death or injury of the eligible participant is the result of a felonious activity, aggravated assault or suicide.
**Beneficiary**

As used herein, “beneficiary” means the person or persons designated to receive any benefits upon the death of an Eligible Employee, Retired Participant, or the legal Spouse of such Eligible Employee or Retired Participant. The designation of a Beneficiary shall be initially made by the Employee when he completes and files a *Participant Data Card* with the Fund Office.

Any Employee may thereafter designate a Beneficiary or change his designated Beneficiary at any time, without the consent or knowledge of the Beneficiary, by filing with the Fund Office a new, completed *Participant Data Card*. A change of Beneficiary will be effective upon receipt in the Fund Office of the newly completed *Participant Data Card*.

If no Beneficiary has been designated, any benefits payable upon the death of an Employee will be paid to his surviving legal spouse. If there is no surviving legal spouse, benefits are paid to his surviving children. If there are no surviving children, benefits are paid to his surviving parents. If there are not surviving parents, benefits are paid to the estate of the deceased Employee.

The Employee shall automatically be deemed to be the Beneficiary for the payment of any benefits upon the death of his legal spouse. The spouse of an Eligible or Retired Participant shall be entitled to designate a Beneficiary under the Plan.

Benefits may be assigned by the designated beneficiary, directly to the Funeral home. Assignment of benefits by any individual(s) other than the designated beneficiary will not be honored.

The Beneficiary must submit written claim for benefits within one (1) year from the date of death.

The designated beneficiary for receipt of death benefits will also be the beneficiary for any medical expenses that had not been paid prior to the date of death.
Section 11. Other Plan Information

Information Required by ERISA

The following information is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA).

Type of Plan

The Plan provides health care and prescription drug coverage, dental coverage, vision coverage, burial benefits, and accidental death and dismemberment benefits.

Name of Plan Administrator

The Michigan Laborers’ Health Care Fund is maintained and administered by a Board of Trustees of which labor and management are equally represented. There are six (6) Labor Trustees and six (6) Management Trustees on the Board. A list of the current Trustees is in the Appendix, “Board of Trustees.”

The Board of Trustees has the primary responsibility for decisions regarding the eligibility provisions, type of benefits, administrative policies, management of Fund assets, and interpretation of Fund provisions.

Plan Year

The Plan year operates on a fiscal year basis commencing September 1 and ending on August 31 of the following year.

Identification Numbers

The Michigan Laborers’ Health Care Fund been assigned employer identification number 38-6058384 by the Internal Revenue Service and assigned to itself identification number 501 for the Department of Labor.

Type of Administration

Although the Board of Trustees is legally designated as the Fund administrator, they have delegated many of the day-to-day functions to TIC and Blue Cross Blue Shield of Michigan.

- TIC maintains the eligibility records, accounts for employer contributions and performs other routine activities under the direction of the Trustees.
- Blue Cross Blue Shield of Michigan processes claims, and keeps participants informed about Plan changes and performs other routine activities under the direction of the Trustees, for the health care and prescription drug coverage.
- TIC keeps participants informed about Plan changes and performs other routine activities under
the direction of the Trustees for burial benefits and accidental death and dismemberment benefits.

Collective Bargaining Agreements

The Michigan Laborers’ Health Care Fund was established and is maintained under the terms of collective bargaining agreements. The agreements set forth the conditions under which the participating employers are required to contribute to the Fund and the rate of contributions. Upon written request, employees may examine the agreements at the Fund Office or at other specified locations. Employees may request a copy of the agreement which will be provided to them at a reasonable charge.

Plan Sponsors

The Fund is maintained under the terms of collective bargaining agreements negotiated by the Union with participating employers. Employers who agree in writing to make contributions to the Fund are considered “plan sponsors.” If any employer is not a party to a written agreement then he generally has no legal obligation to contribute to the Fund on behalf of employees. Consequently, to obtain benefits under this Fund, employees must be working for a contributing employer. If there is any uncertainty about whether or not an employer is a contributing employer, your Local Union Office should be contacted.

Source of Contributions

The primary source of financing for the benefits provided under this Fund and for the expenses of Fund operations is employer contributions. The rate of contribution is spelled out in the collective bargaining agreements negotiated by the Union with participating employers. No money is ever deducted from an employee’s paycheck to pay for these benefits. However, under the terms of the Fund, participants may make self-payments to retain their eligibility if they are temporarily unemployed or temporarily disabled or not work enough hours to satisfy the eligibility provisions. Participants in the Early Retiree, Total and Permanent Disability, and Retiree Self-Payment Programs are required to make self-payments to maintain eligibility for themselves and their dependents. A portion of Fund assets are invested and this also produces additional Fund income to help defray expenses.

Fund Medium for the Accumulation of Fund Assets

All contributions and investment earnings are accumulated in a trust fund.

ERISA Rights and Protections

Participants in the Michigan Laborers’ Health Care Fund are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and
union halls, all Plan documents including: insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Trustees. Under ERISA, Trustees may make a reasonable charge for the actual cost of reproducing the documents and other information.

3. Receive a summary of the Fund’s annual financial report. The Fund administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

4. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate this Fund, called “fiduciaries” of the Fund, have a duty to do so with reasonable care and in the exclusive interest of Plan participants and other beneficiaries.

5. No one may take any action which would prevent a participant from obtaining a benefit to which he is entitled under the Fund or from exercising his rights under ERISA.

6. In accordance with Section 503 of ERISA and federal regulations, the Trustees have adopted certain procedures to protect the rights of participants who are not satisfied with the action taken on a claim. If a claim for benefits is denied, in whole or in part, the participant must receive a written explanation of the reason for denial. Then, if the participant is not satisfied with the action on the claim, he has the right to have the Trustees review and reconsider such claim in accordance with the Fund’s claim review procedures set forth in Section Two (2) of this Summary Plan Description.

7. If a participant has any questions about the Fund, he should contact the Trustees by writing to:

   Board of Trustees  
   Michigan Laborers’ Health Care Fund  
   6525 Centurion Drive  
   Lansing, MI 48917

8. Under ERISA, there are steps participants can take to enforce their rights under the Fund. If materials are requested from the Fund and they are not received, or if the participant feels that the Trustees or employees are discriminating against him for asserting his rights under ERISA, he may seek assistance from the nearest Area Office of the United States Department of Labor or he may file suit in a Federal Court. However, the Fund provides appeal procedures, as set forth in Section Two (2) of this Summary Plan Description, and you must exhaust the Fund appeal procedures before taking other steps.

9. If a participant has any questions about the foregoing statements or about his rights under ERISA which have not been answered in this booklet or by the Fund Office, he should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.

February 2015
# Section 12. Other Important Information

## Employer Trustees

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>
| W.A. Hendrick, Jr., Chairman | R.C. Hendrick & Sons  
619 Foxboro  
Saginaw, MI 48638 | Saginaw | MI | 48638 |
| Gary Benjamin        | Gundlach Champion, Inc.  
180 Traders Mine Road  
Iron Mountain, MI 49801 | Iron Mountain | MI | 49801 |
| Joel Christensen | Mechanical & Industrial Insulation, Inc  
3001 N. Martin Luther King Boulevard  
Lansing, MI 48906 | Lansing | MI | 48906 |
| Dan Emmenecker        | J.R. Heineman & Sons, Inc  
1224 North Niagara St  
Saginaw, MI 48602 | Saginaw | MI | 48602 |
| Scott Fisher          | Associated General Contractors of America,  
Michigan Chapter  
2323 North Larch Street  
Lansing, MI 48906 | Lansing | MI | 48906 |
| Michael Nystrom | Michigan Infrastructure & Transportation Association  
P.O. Box 1640  
Okemos, MI 48805 | Okemos | MI | 48805 |

## Union Trustees

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>
| Geno Alessandrini, Secretary | Michigan Laborers District Council  
1118 Centennial Way, Suite 100  
Lansing, MI 48917-9280 | Lansing | MI | 48917-9280 |
| Michael Aaron         | Laborers’ Local Union 1191  
2161 West Grand Boulevard  
Detroit, MI 48208 | Detroit | MI | 48208 |
| Joseph Gallino        | Laborers’ Local Union 1329  
P.O. Box 863, North US 2  
Iron Mountain, MI 49801 | Iron Mountain | MI | 49801 |
| Dan Husted            | Laborers’ Local Union 1075  
P.O. Box 5188  
G-7024 North Dort Highway  
Mt. Morris, MI 48458 | Mt. Morris | MI | 48458 |
| Robert Malcolm        | Laborers’ Local Union 499  
3080 Platt Road  
Ann Arbor, MI 48108-1808 | Ann Arbor | MI | 48108-1808 |
| Alex Zurek            | Michigan Laborers’ District Council  
1118 Centennial Way, Suite 100  
Lansing, MI 48917-9280 | Lansing | MI | 48917-9280 |
Alternate Employer Trustees

Bart Carrigan  
Associated General Contractors of America, Michigan Chapter  
2323 North Larch Street  
Lansing, MI  48906

Vacancy

Alternate Union Trustees

Bill Bass  
Laborers Local Union 1076  
760 Joslyn Avenue  
Pontiac, MI  48340-0584

Brent Pilarski  
Laborers Local Union 1098  
345 Morley Drive  
Saginaw, MI  48601

Other Fund Contacts

Fund Office  
Michigan Laborers’ Health Care Fund  
6525 Centurion Drive  
Lansing, MI  48917-9275

BCBSM Customer Service Office  
Blue Cross Blue Shield of Michigan  
Major Accounts Service Center  
600 East Lafayette, X420  
Detroit, MI  48226

Legal Counsel - Agent for Service of Legal Process  
Christopher P. Legghio  
Legghio & Israel, P.C.  
306 South Washington, Suite 600  
Royal Oak, MI  48067

Website Addresses

Michigan Laborers Fringe Benefit Funds - [www.michiganlaborers.org](http://www.michiganlaborers.org)  
Blue Cross Blue Shield of Michigan Home Page – [www.bcbsm.com](http://www.bcbsm.com)  
Blue Cross Blue Shield of Michigan Anti-Fraud – [www.bcbsm.com/antifraud/contact.shtml](http://www.bcbsm.com/antifraud/contact.shtml)