LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND

SUMMARY PLAN DESCRIPTION

AND

PLAN DOCUMENT

JANUARY 1, 2022

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INTRODUCTION

We are the Board of Trustees of the Laborers' Metropolitan Detroit Health Care Fund ("Fund"). The Fund Trustees established the Laborers' Metropolitan Detroit Health Care Plan ("Plan").

This Summary Plan Description (SPD) summarizes Plan benefits for you and your eligible family members – medical, pharmacy, dental, vision, hearing care, accidental death and dismemberment and death benefits as of January 1, 2022. These Plan benefits provide comprehensive healthcare coverage and helps to protect you against catastrophic expenses.

This SPD replaces and supersedes any prior Summary Plan Description issued by this Fund. It includes all Plan changes made since the last SPD was printed. This SPD, along with other Plan documents, govern the Plan's operation.

No Benefits are Guaranteed
No Plan benefit is guaranteed. Among other things, we may amend, modify or eliminate any Plan benefits and/or change the Plan's eligibility rules.

Sole Authority to Interpret the Plan
The Fund Trustees have the sole authority and discretion to interpret all Plan documents and to make the final determinations regarding eligibility and benefits. Stated another way, no Employer, Union nor any Employer or Union representative, is authorized to interpret the Plan. Nor can any such person act as the Trustees' agent. You may only rely on Plan information that is in writing and signed by the Board of Trustees or by the Administrator, whose signature must be authorized by the Trustees.

Reading this SPD
Read this SPD carefully to understand what Plan coverage is available, who's eligible for coverage and when Plan coverage begins and ends. If you are married or have other covered dependents, you should share this SPD with them. To assist you when reading this SPD, please consult the SPD Definition sections (**Appendices A and B**) for terms and explanations pertaining to your benefits.

Finally, if you have questions about this SPD or about the Plan, please contact the Fund Office at (800) 228-0048 or (517) 321-7502.

Sincerely,

THE BOARD OF TRUSTEES
LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND

SECTION 1: GENERAL PLAN INFORMATION

A. Plan Administration

Plan Name
Laborers' Metropolitan Detroit Health Care Fund

Plan Administrator
Board of Trustees
Laborers' Metropolitan Detroit Health Care Fund
6525 Centurion Drive
Lansing, Michigan 48917-9275
(517) 321-7502
(800) 228-0048

Employer Identification Number
38-2026006

Plan Number
501

Plan Year
For governmental filing and reporting purposes, the official plan year for the Laborers' Metropolitan Detroit Health Care Fund is October 1 through September 30.

Type of Plan
This Plan is a self-funded plan for medical, pharmacy, dental, vision, hearing, accidental death and dismemberment and death benefits. This means that the Fund accepts full liability for the payment of claims and related expenses.

Medicare Advantage Prescription Drugs (MAPD) benefits are fully insured. This means that the Fund pays a premium for these benefits and the Fund's carrier assumes financial responsibility. MAPD provides medical, hearing and prescription drug benefits to Medicare-enrolled Retirees and Spouses and/or Eligible Dependents.

About the Plan
The Plan's current sponsors are Laborers' Locals 1076 and 1191, the Michigan Laborers' District Council and several Employer Associations – the Associated General Contractors (AGC) of Michigan, the Asbestos & Lead Abatement Contractors Association of Michigan, the Mason Contractors' Association, Inc., Construction Association of Michigan; Architectural Contractors Trade Association, and the Michigan Infrastructure & Transportation Association.

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.

Plan Trustees
The Laborers' Metropolitan Detroit Health Care Fund is maintained and administered by a Board of Trustees of which labor and management are equally represented. There are six Labor Trustees and six Management Trustees on the Board. These "Plan Trustees" have the primary responsibility for decisions regarding the eligibility provisions, type of benefits, administrative policies, management of Fund assets and interpretation of Fund provisions.

Contact information about the Plan Trustees is located in **Appendix C** of this SPD**.**

B. Type of Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Board of Trustees is the legally designated Plan Administrator. To the fullest extent permitted by law and applicable contracts, the Plan Administrator has the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator also has the discretion to determine all matters relating to interpretation and operation of the Plan and to make factual determinations. Any determination by the Plan Administrator, or any authorized delegate, is final and binding.

As Plan Administrator, the Board of Trustees has delegated many of the day-to-day functions to a third-party administrator, TIC International Corporation (the Fund Office), and to our benefit providers.

- TIC International Corporation (Fund Office) maintains the eligibility records, accounts for Employer Contributions, keeps participants informed about Plan changes, administers death and disability benefits, and performs other routine activities under the direction of the Trustees.
- The benefit providers process claims and perform other routine activities under the direction of the Trustees.

Collective Bargaining Agreements
The Fund was established and is maintained under the terms of collective bargaining agreements (CBAs). These Union negotiated agreements set forth the conditions under which employers are required to contribute to the Fund and the rate of contributions (Employer Contributions) and/or any other conditions for participation in the Plan. Upon written request, employees may examine the agreements at the Fund Office or at other specified locations. Employees may request a copy of the agreements which will be provided to them at a reasonable charge.

Plan Sponsors
Employers who are bound by CBAs to make contributions to the Fund are participating employers. They are considered "Plan Sponsors." If any employer is not a party to a written agreement, then the employer 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 determining whether or not an employer is a participating employer, you should contact your Union Office.

Upon written request, the Board of Trustees will confirm whether a particular employer or employee organization is a sponsor of the Plan. The Board of Trustees will also provide the address of Plan Sponsors.

C. Source of Funding

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 outlined in the collective bargaining agreement.

D. Fund Medium for the Accumulation of Fund Assets

All contributions and investment earnings are accumulated in a trust fund, the Laborers' Metropolitan Detroit Health Care Fund.

E. Name and Address of Benefit Providers

Medical, Pharmacy, Vision, Hearing and Medicare Advantage Prescription Drug (MAPD) Benefits
BLUE CROSS BLUE SHIELD OF MICHIGAN
600 E. Lafayette Blvd.
Detroit, MI 48226
(313) 225-9000
www.bcbsm.com

Dental Benefits
DELTA DENTAL
P.O. Box 9085
Farmington Hills, MI 48333-9085
(800) 524-0149
www.deltadental.com

Accidental Death & Dismemberment (AD&D) and Death Benefits
Laborers' Metropolitan Detroit Health Care Fund
6525 Centurion Drive
Lansing, MI 48917-9275
(800) 228-0048 or (517) 321-7502
www.metrodetroitlaborers.org

F. Agent for Service of Legal Process

If, for any reason, you wish to seek legal action, you may serve legal process on the Plan Administrator by delivering it to the Agent for Service of Legal Process at the following address:

Lauren Crummel
Watkins, Pawlick, Calati & Prifti, PC
1432 E. 12 Mile Rd
Madison Heights, MI 48071
248-658-0800

Service of legal papers also may be made directly upon the Plan Administrator.

G. Fund Office

TIC INTERNATIONAL CORPORATION
655 Centurion Drive
Lansing, MI 48917
(800) 228-0048
(517) 321-7502

H. Internet Access

You may access your fringe benefit fund information via the internet at the Laborers' Metropolitan Detroit website: www.metrodetroitlaborers.org which includes plan documents, forms and other useful information.

I. Information You Must Provide the Plan

Providing Information – Your Responsibility
Providing timely and accurate information to the Plan is your responsibility. All changes regarding your dependents must be in writing and supported by appropriate documentation (birth certificate, marriage license, adoption papers, etc.). You must also notify the Fund Office in writing of any change in your contact information or your beneficiary.

Inaccurate information or improper documents may result in processing errors or the improper use of Plan assets. If you or a dependent fail to submit requested information, make a false statement, or furnish fraudulent or incorrect information, your (and/or your dependent(s)) Plan benefits, including continued participation in the Plan, may be denied, suspended or discontinued temporarily or permanently by the Board of Trustees. For questions and/or assistance, please contact the Fund Office.

NOTE: The Fund Office and your local union are separate entities. Therefore, you must separately notify your local union of an address change.

Health Care Enrollment Form
The Fund Office will supply you with a Health Care Enrollment Form requiring details such as your address, phone number, list of dependents, beneficiaries, etc. You must also supply appropriate documentation (birth certificate, marriage license, etc.) along with your completed form. Failure to do so may affect timely processing of your health care benefits.

SECTION 2: ELIGIBILITY

Eligible Employee
This Plan defines an Eligible Employee as an employee who meets the Eligibility Requirements outlined in this section. An Eligible Employee may also be referred to as an **"Active Employee."** Once you meet Initial Eligibility, the Plan provides benefits for you, your Spouse and/or your Eligible Dependents.

Spouse
Your Spouse is your legal spouse.

Eligible Dependent(s)
Your Eligible Dependent(s) include:

- Your child(ren) by birth, legal adoption, or full legal guardianship

  Note: A child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

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

NOTE: Eligible Dependents are covered through the end of the month the dependent turns age twenty-six (26).

Disabled Dependent(s)
Disabled dependent(s) may continue coverage beyond age twenty-six (26) if:

- The dependent child is disabled prior to age twenty-six (26) and you notify the Fund Office of the condition in writing.
- The disability is from a medically determined mental or physical condition that prevents your dependent from being self-supporting.
- The dependent child is unmarried and dependent on you for support and care.
- A doctor's certification of disability is provided.

A. Initial Eligibility Requirements

To become initially eligible for Plan benefits, your Employer must have made contributions on your behalf for at least seven hundred (700) hours within six (6) consecutive months or less. **Only Employer Contributions are counted for Initial Eligibility purposes.**

Plan coverage will start the first day of the second month after you have met the eligibility requirement. You, your Spouse and/or your Eligible Dependent(s) will have three (3) months of Plan coverage.

Below are some examples of how you become eligible for Plan benefits:

> ***Example 1***: If you work and an employer contributes 700 hours for the months of January, February, March, April, May and June --six consecutive months -- you and your eligible family members will have coverage during August, September and October.
>
> ***Example 2*****:** If you work and an employer contributes totals 700 hours for the months of January, February, March, April, May -- five consecutive months -- you and your eligible family members will have coverage for the months of July, August and September.

How your hours are earned during the six (6) or less consecutive months is ***not*** important when establishing Initial Eligibility. Instead, what's important is that an ***Employer*** contributes a total of seven hundred (700) hours in contributions on your behalf ***within*** a period of six (6) consecutive months or less.

Note: Reciprocity hours may be used to attain Initial Eligibility (see Reciprocity for Initial and Continuing Eligibility below). Additionally, you do not have to satisfy the Initial Eligibility requirement

if you have been eligible via Employer Contributions with the Michigan Laborers' Health Care Fund within the latest sixty (60) month period and this Fund is now your Home Fund.

B. Continuing Eligibility

Once you have satisfied the Initial Eligibility Requirement, you can earn Continuing Eligibility through a combination of the Plan's Quarterly and Annual Eligibility provisions up to a maximum of six (6) months. Your Continuing Eligibility requirements are determined on a rolling basis.

You will remain eligible for two (2) months of eligibility if the Fund receives employer contributions on your behalf for three (3) consecutive months for at least three hundred fifty (350) hours.

Example 1: 350 hours of contributions are paid on your behalf by a Contributing Employer for the months of March, April and May. You and your family will be eligible for benefits for the months of June and July.

You must satisfy the following hour requirements in the given timeframe to maintain eligibility:

seven hundred (700) hours in six (6) months for 3 months of coverage;
one thousand fifty (1,050) hours in nine (9) months for four (4) months of coverage;
one thousand four hundred (1,400) hours in twelve (12) months for five (5) months ; and
one thousand seven hundred fifty (1,750) hours in twelve (12) months for six(6) months of coverage.

Example 2: 1,750 hours of contributions are paid on your behalf by a contributing employer for the months of January through December, you and your family will be eligible for benefits for the months of January through June of the following year.

Reinstatement

If you are ineligible for thirteen (13) or more consecutive calendar months, you must again satisfy the Initial Eligibility Requirements to again be eligible for Plan benefits. But, if during this period you were eligible for benefits under the Michigan Laborers' Health Care Fund, you may not have to satisfy Initial Eligibility Requirements to be eligible for Plan benefits. See Reciprocity for Initial and Continuous Eligibility below.

Note: In the event of your death while you are an Active Employee, your surviving Spouse and/or Eligible Dependent(s), may use your remaining months of eligibility to continue Plan coverage. They will not need to make payments until your months of eligibility are exhausted. Once your continued eligibility has been exhausted, coverage may continue through the Surviving Spouse Self-Payment program or COBRA continuation coverage program. Your Spouse and/or Eligible Dependent(s) are not considered Active Employees.

C. Reciprocity for Initial and Continuing Eligibility

The Trustees have reciprocity agreements with other Health Care Funds covering laborers in the United States and Canada. Under these reciprocity agreements, contributions made on your behalf are transferred from one Health Care Fund to another upon your written request and authorization. The contributions that are transferred may enable you to meet the eligibility provisions of this Fund.

If you work in another jurisdiction and have Employer Contributions made to another Health Care Fund on your behalf, you should request that contributions be transferred, via a reciprocity agreement, to this Fund. Contact your Local Union Office or the Fund Office to see if a reciprocity agreement exists between this Fund and the other Health Care Fund and, if so, sign the necessary request form to effect a transfer.

Please note that incoming reciprocity contributions are **"pro-rated."** That means, if the contribution rate where you were working is less than the Fund's contribution rate, the hours this Fund credits you with may be less than the hours you worked for the reciprocating fund.

> **Example:** Assume the Fund's contribution rate is $10 per hour. If you work 100 hours out of town, and the contribution rate is only $8 per hour, you will only be credited with 80 hours (instead of the 100 hours you worked) because the hours are pro-rated. (The opposite is true if the contribution rate where you worked is higher than the Fund's rate.)

D. Disability Hour Credit

If you are unable to work because of an injury or illness, you will receive Disability Hour Credit, six (6) hours per day, during the period of your temporary disability. **You must have continuous eligibility by Employer Contributions or self-payments to qualify for the Disability Hour Credit at the time of your injury or illness**. You are required to complete a Statement for Loss of Time Benefits form and an Accidental Injury Questionnaire, if applicable.

You will be provided with a maximum of one-hundred twenty (120) hours per month for a maximum of fifty-two (52) weeks if your disability persists. Periodic statements from your attending physician (MD or DO or DPM if your disability is related to a foot or ankle) or a Fund-selected physician will be required as documentation of your continuing disability.

If you do not return to work and your disability lasts for fifty-two (52) weeks, the Fund Office will notify you that you have exhausted your available Disability Hour Credit.

Claims for Loss of Time Benefits must be submitted within one (1) year of the first date of illness or injury.

Contact the Fund Office for forms and/or more information regarding Disability Hour Credit.

E. Miscellaneous Provisions

1. Both Spouses Eligible as Employees (also in COB section)

If you and your Spouse are each employed as a laborer and you are each eligible as an Active Employee, the Plan will coordinate health care benefits for any claims incurred by you, your Spouse and/or your Eligible Dependents during the period of dual coverage.

2. Working Aged and Medicare Secondary Payer Rules

If you continue to work beyond age sixty-five (65) and you are Medicare eligible, you are considered a "working aged" under the Medicare Secondary Payer (MSP) rules. As a working aged, you have the option of choosing between the Plan and Medicare as your primary plan. However, if you choose Medicare as your primary plan, you are prohibited from receiving Plan benefits. This includes your Spouse and/or any Eligible Dependents who may also be eligible for Medicare.

If you maintain Plan coverage, the Plan is primary for you, your Spouse, and/or Eligible Dependent(s). If your Spouse or Eligible Dependents become eligible for Medicare benefits, the Plan remains primary for the Spouse and Eligible Dependents until you no longer meet the definition of an Active Employee.

If for some reason you would rather have Medicare as your primary payer, you must state this preference in writing and send it to the Fund Office. Contact the Social Security Administration at (800) 531-2244 or visit the Medicare website at www.medicare.gov for questions or if you need assistance in fully understanding your options as a working aged.

SECTION 3: ACTIVE EMPLOYEE SELF-PAYMENT PROGRAM

If you do not have enough Employer Contributions to remain eligible for Plan benefits and you are on the Union's out-of-work list, you can remain eligible for up to **eighteen (18) consecutive months** by making self-payments under the Self-Payment Program. You must remain available for work within the jurisdiction of one of the participating Local Unions in order to be eligible to make self-payments. Your health care benefits remain the same while you have coverage through the Self-Payment Program as an Active Employee**.**

Note: You are not eligible for the Self-Payment Program if you voluntarily leave covered employment to find or take a job in another industry or you become self-employed**.**

When you are no longer eligible for Plan benefits through Employer Contributions, the Fund Office will notify you of your self-payment rights, the applicable self-payment rate and the payment due date. Coverage is terminated if you fail to timely remit self-payments.

You should make your self-payment when due even if you think you should be eligible by way of Employer Contributions. If after your self-payment is made, the Fund Office receives late Employer Contributions on your behalf which would have been sufficient for Continuing Eligibility, the Fund Office will make the appropriate refund of your self-payment to you.

Notification for the Self-Payment Program will be sent to the last address you provided to the Fund Office. Therefore, you must keep the Fund Office informed of your current address. Failure to make a self-payment by the notification due date or because you did not receive notice due to an incorrect or old address will make you ineligible for the Self-Payment Program.

Self-payments can be made by check or money order payable to the "Laborers' Metropolitan Detroit Health Care Fund." Payment can be made at the Fund Office or mailed to:

Laborers' Metropolitan Health Care Fund
6525 Centurion Drive
Lansing, MI 48917

Credit card payments are acceptable when made by phone and prior to the due date. You must authorize payments for each self-payment. Contact the Fund Office for assistance.

Aside from the Self-Payment Program, if you and/or your eligible family members lose Fund eligibility, you may be eligible for COBRA continuation coverage benefits. See Section 9 COBRA.

SECTION 4: EARLY RETIREE & RETIREE SELF-PAYMENT PROGRAM

A. Eligibility Provisions

If you become an Early Retiree (under age sixty-five) or a Retiree at age sixty-five (65) or older, you may be able to continue coverage for yourself, your Spouse and/or your Eligible Dependent(s) by making self-payments through the Retiree Self-Payment Program**.** See Section 7 for making Self-Payments.

To continue eligibility in the Plan you must:

- be eligible to receive monthly pension benefits from the Laborers' Pension Trust Fund — Detroit & Vicinity or the Laborers' International Pension Fund;
- have been eligible under the Plan at least once by way of Employer Contributions in at least five (5) of the last ten (10) years preceding your retirement;
- be eligible at the time of retirement by either Employer Contributions, Disability Hour Credit or self-payments on the date of your retirement to participate in the Early Retiree or Retiree Self-Payment Program;
- be a member in good standing with your Local Union; and
- participate in the Early Retiree or Retiree Self-Payment Program immediately upon termination of coverage as an Active Employee.

B. Schedule of Benefits

The schedule of benefits for you, your Spouse and/or your Eligible Dependent(s) is based on the status of each family member (*i.e.*, non-Medicare or Medicare eligible) on your retirement date as follows:

1. Not Eligible for Medicare (Early Retiree)

If you retire prior to age sixty-five (65), and you and your family members are **not** eligible for Medicare, benefits are the same as the schedule of benefits when you were
an Active Employee except:

- Death benefits will be lower
- Disability Hour Credit will no longer be applicable
- Accidental death and dismemberment benefits will no longer be applicable

2. Eligible for Medicare (Retiree)

If you retire at age sixty-five (65) or later, or prior to age sixty-five (65) and are eligible for Medicare due to a disability **and** you and your family members are eligible for Medicare, the following applies:

- Death benefits will be lower
- Disability Hour Credit will no longer be applicable
- Accidental death and dismemberment benefits will no longer be applicable
- Medical, prescription drug and hearing benefits will be provided under the Medicare Advantage Prescription Drug (MAPD) Program. Dental and vision benefits will continue

3. Non–Medicare and Medicare Eligible

If you retire (regardless of age) and you **and** your family members have a mixed status (i.e., Pre-Medicare and Medicare Enrolled), benefits for each family member are as follows:

- Family members **not** enrolled in Medicare will receive the same benefits as an Active Employee.
- Family members enrolled in Medicare will receive medical, prescription drug and hearing benefits under the Medicare Advantage Prescription Drug (MAPD) Program. Dental and vision benefits will continue.

Note: At the time of your retirement, you must notify the Fund Office immediately if you, your Spouse and/or Eligible Dependent(s) are eligible for Medicare. If you, your Spouse and/or Eligible Dependent(s) become eligible for Medicare, you must enroll in Medicare Parts A and B and notify the Fund Office. A copy of the Medicare card is also required.

C. Provisions for Continued Participation

You may continue coverage for yourself, your Spouse and/or Eligible Dependent(s) under the Early Retiree/Retiree Self-Payment Program until one of the following occurs:

- Failure to remit timely self-payments
- Failure to pay the proper amount
- Failure to remain a member in good standing with your Local Union
- Termination or modification of the Early Retiree or Retirement Self-Payment Program

In addition to the above reasons for loss of coverage, your Spouse and/or Eligible Dependent(s) will be terminated from the Plan if:

- Your Spouse no longer meets the definition of Spouse
- Your child(ren) no longer meets the definition of an Eligible Dependent
  (See COBRA Section 9 for possible continuation of benefits.)

In the event of your death, your Spouse and/or Eligible Dependent(s) may be eligible to continue coverage through the Surviving Spouse Self-Payment Program or COBRA benefits. (See Sections 7 and 9.)

Note: If you discontinue remitting self-payments or are untimely in your self-payment, Plan coverage will terminate automatically on the first (1st) day of the month following the month for which your last payment was made. **This termination of coverage is automatic.** You will not receive a notification of termination.

D. Special Provisions

- If you are single and remitting self-payments and then marry, you may begin coverage for your new Spouse effective with the date of marriage provided that proof of your marriage is submitted to the Fund Office within thirty (30) days from the date of such marriage along with the additional self-payment amount, if required.

- If you acquire dependent children, notification and proper documentation (birth certificates, adoption papers, full legal guardianship papers, etc.) must be submitted to the Fund Office within thirty (30) days along with the additional self-payment amount, if required, for such coverage. Eligible Dependent(s) will be covered effective as of the date the child(ren) meets the definition of an Eligible Dependent provided the Fund Office has received proper documentation of such status.
- **If you return to work,** at the trade, you must remit self-payments at the Early Retiree/ Retiree Self-Payment rate until such time that you satisfy the eligibility provisions of an Active Employee. **Note: You must notify the Fund Office immediately if you return to work**

- Non-military service-related treatment provided by a Veterans Administration facility to you and/or your eligible family members *who are also covered by Medicare* **is not covered by the Plan, unless** required by law**.** Medicare does not provide any payment for these services. **Any charges incurred by you, your Spouse and/or Eligible Dependent(s) for such non-military service-related treatment may be your responsibility.**

SECTION 5: TOTALLY & PERMANENTLY DISABLED RETIREE SELF-PAYMENT PROGRAM

If you become totally and permanently disabled (T & PD) prior to age sixty-five (65), you may be eligible to continue Plan benefits for yourself, your Spouse and/or Eligible Dependent(s) by making self-payments through the Totally & Permanently Disabled Retiree Self-Payment Program. See Section 7 for making Self-Payments.

A. Eligibility Provisions

To continue eligibility in the Plan as a T&PD retiree, you must:

- have been eligible under this Plan at the time your disability began and have been continuously disabled for a period of twenty-six (26) weeks;
- have been eligible at least once by way of Employer Contributions in at least five (5) of the last ten (10) years preceding your disability;
- have been eligible by either Employer Contributions or self-payments on the date of your retirement;
- have continued coverage through Employer Contributions, Disability Hour Credits or self-payments immediately upon termination of coverage as an Active Employee;
- be receiving monthly pension benefits from the Laborers' Pension Trust Fund - Detroit & Vicinity or the Laborers' International Pension Fund.

B. Schedule of Benefits

The schedule of benefits for you, your Spouse and/or your Eligible Dependent(s) is based on the status of each family member (*i.e.*, non-Medicare or Medicare eligible) on your T&PD retirement date as follows:

1. **Not Eligible for Medicare (T&PD Retiree)**

   If you retire as a T&PD Retiree and you and your family members are not eligible for Medicare, benefits are the same as the schedule of benefits as an Active Employee except:

   - Death benefits will be lower
   - Disability Hour Credit will no longer be applicable
   - Accidental death and dismemberment benefits will no longer apply

2. **Eligible for Medicare (T&PD Retiree)**

If you retire as a T&PD Retiree and are eligible for Medicare due to a disability and your family members are eligible for Medicare, the following applies:

- Death benefits will be lower
- Disability Hour Credit will no longer be applicable
- Accidental death and dismemberment benefits will no longer be applicable
- Medical, prescription drug and hearing benefits will be provided under the Medicare Advantage Prescription Drug (MAPD) Program. Dental and vision benefits will continue.

3. Non-Medicare and Medicare Eligible

If you are a T&PD retiree and you and your family members have a mixed status (i.e., Pre-Medicare and Medicare Enrolled), benefits for each family member are as follows:

- Family members not enrolled in Medicare will receive the same benefits as an Active Employee.
- Family members enrolled in Medicare will receive medical, prescription drug and hearing benefits under the Medicare Advantage Prescription Drug (MAPD) Program. Dental and vision benefits will continue.

Note: At the time of your retirement, you must notify the Fund Office immediately if you, your Spouse and/or Eligible Dependent(s) are eligible for Medicare. If you, your Spouse and/or Eligible Dependent(s) become eligible for Medicare, you must enroll in Medicare Parts A and B and notify the Fund Office. A copy of the Medicare card is also required.

C. Provisions for Continued Participation

You may continue coverage for yourself, your Spouse and/or Eligible Dependents under the Totally & Permanently Disabled Retiree Self-Payment Program until one of the following occurs:

- Failure to remit timely self-payments
- Failure to pay the proper amount
- Failure to remain a member in good standing with your Local Union
- Termination or modification of the Totally & Permanently Disabled Retiree Self-Payment Program

In addition to the above reasons for loss of coverage, your Spouse and/or Eligible Dependent(s) will be terminated from the Plan if:

- Your Spouse no longer meets the definition of Spouse.
- Your child(ren) no longer meets the definition of an Eligible Dependent
  (See Section 9 COBRA for possible continuation of benefits).

In the event of your death, your Spouse and/or Eligible Dependent(s) may be eligible to continue coverage through the Surviving Spouse Self-Payment Program or COBRA benefits. (See Sections 6 and 9.)

Note: If you discontinue remitting self-payments or are untimely in your self-payment, Plan coverage will terminate automatically on the first (1st) day of the month following the month for which your last payment was made. **This termination of coverage is automatic.** You will not receive a notification of termination.

D. Special Provisions

- If you are single and remitting self-payments and then marry, you may begin coverage for your new Spouse effective as of your marriage date provided that proof of your marriage is submitted to the Fund Office within thirty (30) days from the date of such marriage along with the additional self-payment amount, if required.

- If you acquire dependent children, notification and proper documentation (birth certificates, adoption papers, full legal guardianship papers, etc.) must be submitted to the Fund Office within thirty (30) days along with the additional self-payment amount, if required, for such coverage. Eligible Dependent(s) will be covered effective as of the date the child(ren) meets the definition of an Eligible Dependent, provided the Fund Office has received proper documentation of such status.

- **If you return to work**, you will be required to remit self-payments under the T&PD Retiree Self-Payment Program until such time that you satisfy the eligibility provisions of an Active Employee. It is your responsibility to notify the Fund Office in writing if you return to work so that a review of your status can be completed. **Note:** You must notify the Fund Office in writing if you retire again.

- Non-military service-related treatment provided by a Veterans Administration facility to you and your eligible family members/ *who are also covered by Medicare* is not covered by the Plan, unless required by law. Medicare does not provide any payment for these services. Any charges incurred by you, your Spouse, and/or Eligible Dependent(s) for such non-military service-related treatment will be your responsibility.

E. Information About Medicare

If the Social Security Administration determines that you have been disabled for a period of twenty-four (24) consecutive months, generally you are entitled to Medicare coverage. At that time, you must apply for disability benefits from Social Security and enroll in both Parts A and B of Medicare. You must also provide the Fund Office with a copy of your Medicare card.

If your Spouse and/or Eligible Dependent(s) are eligible for Medicare at the time you qualify for the Totally and Permanently Disabled (T&PD) Retiree Self-Payment Program, you must notify the Fund Office of such in conjunction with your application for continued eligibility in the Plan. If your Spouse and/or Eligible Dependent(s) subsequently become eligible for Medicare, immediate enrollment in Medicare Parts A and B of Medicare is required along with providing a copy of their Medicare card to the Fund Office.

SECTION 6: SURVIVING SPOUSE SELF-PAYMENT PROGRAM

A. Eligibility Provisions

The Surviving Spouse and/or Eligible Dependent(s) of a deceased Active Employee or Retiree are eligible for continued coverage under the Surviving Spouse Self-Payment Program. To continue eligibility in the Plan, your Surviving Spouse (and/or Eligible Dependent(s)) must have been enrolled in the Fund at the time of your death.

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B. Schedule of Benefits

The following benefits are not applicable for the Surviving Spouse (and Eligible Dependents):

- Death benefits; and
- Accidental death and disability benefits.

1. Not Eligible for Medicare

If a Surviving Spouse (and Eligible Dependent(s)) is not eligible for Medicare, health care benefits will remain the same as in effect at the time of the decedent's death.

2. Eligible for Medicare

If a Surviving Spouse (and Eligible Dependent(s)) is or becomes eligible for Medicare, enrollment in Medicare Parts A and B is required effective with the Medicare eligibility date. Notification must be made immediately to the Fund Office. A copy the Medicare card is also required.

Benefits for a Medicare enrollee for medical, prescription drug and hearing care benefits will be provided under the Medicare Advantage Pharmacy Drugs (MAPD) Program. See Section 21. Dental and vision benefits remain the same as an Active Employee.

Self-payments are not required from a Surviving Spouse and/or Surviving Eligible Dependent(s) if the deceased participant has continued eligibility through Employer Contributions or Disability Hour Credit. Once continued eligibility ends, self-payments are required.

C. Provisions for Continued Participation

Coverage for the Surviving Spouse and Eligible Dependent(s) will terminate on the first day of the month following one of these events:

- Remarriage of the Surviving Spouse.
- Failure to remit a self-payment in the correct amount by the specified due date.
- Termination or modification of the Surviving Spouse Self-Payment Program.

In addition to the above reasons for loss of coverage, Eligible Dependent(s) will be terminated on the first day of the month following failure to meet the definition of an Eligible Dependent.

Note: Eligible Dependents who lose coverage due to any of the above provisions may be eligible for benefits through COBRA. See Section 9: COBRA continuation coverage.

D. Special Provisions

Once coverage is elected under the Surviving Spouse Self-Payment Program, continuous coverage must be maintained through self-payments. If coverage is terminated for any reason, the Surviving Spouse (and Eligible Dependent(s)) will not be permitted to make self-payments at any future time.

SECTION 7: Retiree/Early Retiree, T&PD Retiree And Surviving Spouse Self-Payment Due Dates And Provisions

A. Eligibility

To maintain eligibility in the Self-Payment program, payment is due in the Fund Office by the first (1st) day of the month for which coverage is provided.

For example, for September coverage, your self-payment is due in the Fund Office by September 1.

B. Methods of Payment

Payments can be made as follows:

- check or money order payable to the "Laborers' Metropolitan Detroit Health Care Fund." Self -payments can also be made directly at the Fund Office or can be mailed to:

  Laborers' Metropolitan Health Care fund
  6525 Centurion Drive
  Lansing, MI 48917-9275

- credit card
  - Credit card payments made at the Fund Office (above) or by phone and prior to the due date. You must authorize payments for each self-payment.

- direct debit
  - From a personal bank account (i.e., a checking or savings account).

  - The Direct Debit Authorization Agreement, available from the Fund Office, must be executed by the fifteenth (15^{th}) day of the month preceding the month such deductions are to begin.

  - Cancellation of the deductions must be made in writing at least sixty (60) days prior to the effective date of cancellation.

- deduction from your Laborers' Pension Trust Fund monthly benefit check: Detroit & Vicinity; or the Laborers' International Pension Fund. Contact the Fund Office for the appropriate authorization form.

A self-payment for up to six (6) months in advance is also an option. Upon receipt of the self-payment, the Fund Office will send only one notification to you specifying the due date and amount of your next self-payment. You must remit your next self-payment in a timely manner because no additional notifications will be sent.

Note: The Trustees establish the amount of the monthly self-payment and may change this amount periodically. For current self-payment rates, call the Fund Office at (800) 228-0048 or (517) 321-7502.

SECTION 8: COVERAGE DURING LEAVES OF ABSENCE

A. Continuation of Coverage under FMLA

A contributing employer which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA") is required to notify the Fund when an Eligible Employee has been granted family or medical leave, in accordance with the terms and conditions established by the Board of Trustees. Both the employer and the Eligible Employee are required to provide the notices, information and documentation as may be required by the Board of Trustees and by law. The Fund will continue coverage during the period of any leave for which an Eligible Employee is eligible under the provisions of the FMLA provided the employer remits the required contributions and fully complies with all requirements established by the Board of Trustees. If you have questions, contact your employer.

B. Continuation of Coverage under USERRA

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA") if you leave covered employment to enter service in the armed forces, or other uniformed services of the United States, your accrued eligibility will be frozen, and you may elect to continue coverage for all benefits under the Plan, except Non-Medical Benefits, for a period which is the lesser of:

- The twenty-four (24) month period beginning on the last day of covered employment; or
- The day you, the employee, fail to apply for or return to covered employment.

If you elect to continue coverage, you will be charged the monthly COBRA premium rate, unless your period of service is less than thirty-one (31) days, in which case coverage shall be provided at no additional cost.

You must return to covered employment or register on the Union's out-of-work list within ninety (90) days of your discharge under honorable conditions from the uniformed services or within twenty-four (24) months of discharge if you are recovering from an illness or injury incurred during or aggravated by your service. Upon return to covered employment or registration on the Union's out-of-work list, your accrued hours, if any, shall be restored. You shall be eligible for coverage without having to reestablish eligibility. You will also need to submit copies of your induction and discharge papers to the Fund Office.

SECTION 9: COBRA CONTINUATION COVERAGE

This section is intended to explain to you, your Spouse, and/or your Eligible Dependent(s), in a summary fashion, about *rights and obligations* under the health care continuation coverage

provisions of the Consolidated Omnibus Budget Reconciliation Act, or "COBRA." You, your Spouse (if any), and/or your Eligible Dependents (if any) should take time to read this section carefully.

A. Definitions

COBRA Costs
The COBRA rate (i.e., the cost to you) is determined annually. Contact the Fund Office for questions about the amount.

Continuation Coverage
The coverage available to you and your eligible family members 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.

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 and/or your dependent child(ren).

Qualifying Event
An event that causes you and/or one or more members of 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 up to eighteen (18), twenty-nine (29) or thirty-six (36) months.

B. Employee's Right to Elect Continuation Coverage

You, as a Qualified Beneficiary, have the right to choose health care Continuation Coverage if you lose eligibility for coverage under the Plan:

- due to a reduction in the amount of Employer Contributions remitted;
- termination of employment for any reason, unless termination is due to gross misconduct on your part; or
- start of military service if you perform military duty for more than 30 days.

Each of these 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 up to 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 included on submitted Employer Contribution forms. The Fund Office will determine when the Qualifying Event has occurred within one hundred twenty (120) days following receipt of the Employer Contribution form. The Fund Office will mail a 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 make an election for coverage within sixty (60) days, you no longer have a right to elect 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 are still entitled to elect Continuation Coverage for themselves as long as their election is made within the same election period in which you qualify.

C. Your Spouse's Right to Elect Continuation Coverage

Spouses of employees 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 for any of the following reasons:

- Termination of your employment (for reasons other than gross misconduct), or a reduction in the hours worked by you which results in your losing eligibility under the Fund;
- Your death;
- 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 reasons are known as Qualifying Events for your Spouse. The first Qualifying Event entitles your Spouse to elect up to eighteen (18) months of Continuation Coverage. The other Qualifying Events entitle your Spouse to elect up to thirty-six (36) months of Continuation Coverage.

D. Your Dependent Children's Right to Elect Continuation Coverage

Your dependent children covered under the Plan, as Qualified Beneficiaries, have the right to elect Continuation Coverage if they lose their eligibility for coverage under the Plan for any of the following reasons:

- Termination of covered employee's employment (for reasons other than gross misconduct) or a reduction in the number of hours worked by the 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 the parents – at least one of whom remains covered under the Plan;
- The covered employee becomes entitled to Medicare and either is not eligible to continue coverage for the children or chooses not to continue such coverage; or
- The child or children cease to satisfy the Plan's definition of a "dependent child."

These reasons are known as Qualifying Events for your dependent children. The first Qualifying Event entitles your dependent children to elect up to eighteen (18) months of Continuation Coverage. The other Qualifying Events entitle your dependent children to elect up to 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. But, 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 up to eighteen (18) or thirty-six (36) months, depending on the Qualifying Event, even if the child's parent(s) do not elect Continuation Coverage.

E. Continuation Coverage for Disabled Persons

If you, as a covered employee, your Spouse, or any dependent children, as Qualified Beneficiaries, qualify for Social Security disability benefits at the time of a Qualifying Event that entitles the Qualified Beneficiary to elect eighteen (18) months of Continuation Coverage (or 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).

This additional Continuation Coverage may be purchased not only for the disabled person but also for other family members who are not disabled (subject to the payment of the applicable premium).

To obtain this additional Continuation Coverage, 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.

The Fund is permitted to charge a higher premium (up to one-hundred fifty percent (150%) of the regular COBRA premium) for up to eleven (11) additional months of Continuation Coverage available to disabled persons and their families. The higher premium applies to the disabled person and to other non-disabled family members who opt for this 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 once disabled person is determined by 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 he or she is no longer disabled.

F. Employee Obligations to Notify the Fund Office of a Qualifying Event

Under COBRA, you or a family member must notify the Fund Office within sixty (60) days 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.

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 Continuation Coverage.

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 at any time you or a family member later becomes covered under another group health care plan, including Medicare.

G. Second Qualifying Events

The following rules concerning the occurrence of a second Qualifying Event 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 a second Qualifying Event should occur during the eighteen (18) months of coverage available as a result of the first Qualifying Event [or, up to twenty- nine (29) months if the eleven (11) month extension due to disability applies], then you may purchase additional Continuation Coverage for up to a total of 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 dependent children, the dependent 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.).

This thirty-six (36) months total of Continuation Coverage available when a second Qualifying Event occurs includes the number of months you have already been covered under Continuation Coverage because of the first Qualifying Event. The thirty-six (36) month total is not in addition to any months of Continuation Coverage you have already had because of the first Qualifying Event. The Fund Office must be notified within sixty (60) days of the second Qualifying Event or the additional extended coverage will not be allowed.

For your reference, below is a table that summarizes COBRA Qualifying Events and the length of coverage available, including any extensions for which you may qualify:

Qualifying Event	**Maximum Continuation Period**		
	Employee	**Spouse**	**Child**
Reduction in work hours	18 months	18 months	18 months
Termination (other than for misconduct)	18 months	18 months	18 months
You're determined to be disabled by the SSA	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your Spouse divorce	N/A	36 months	36 months
Your child no longer qualifies as a dependent	N/A	N/A	36 months

H. Proof of Insurability is Not Necessary to Elect Continuation Coverage

You and your family members do not have to show that you 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.

I. Procedure for Obtaining Continuation Coverage

Once the Fund Office knows that an event has occurred which qualifies you or other family members for Continuation Coverage, the Fund Office will attempt to notify you or your family member of their rights to elect Continuation Coverage.

Once you receive this election notice, 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.

J. Termination of Continuation Coverage

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

- The Fund no longer provides group health care coverage to any employees;
- The required self-payment for Continuation Coverage is not paid on time;
- The person remitting Continuation Coverage payments becomes covered under another group health care plan, after the Qualifying Event;
- 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 a 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 a dependent child is not covered by Medicare.

K. Option to Enroll in Medicare instead of COBRA continuation coverage after Group Health Plan Coverage Ends

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

SECTION 10: COORDINATION OF BENEFITS, SUBROGATION, NO FAULT AUTO INSURANCE

A. Coordination of Benefits (COB)

COB is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans. Your Blue Cross Blue Shield 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 one-hundred percent (100%) of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your eligible family members. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

1. How COB Works

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

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

2. Both Spouses Eligible as Employees

If both Spouses are employed as Laborers and are both Eligible Employees, the Fund will coordinate benefits for any claims incurred by either Spouse and for any Eligible Dependents during the period of dual coverage.

3. Guidelines to Determine Primary and Secondary Plans

Contract Holder vs. Dependent Coverage
The plan that covers the patient as the employee (subscriber or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts)
If you are the contract holder of more than one health care plan, your primary plan is the one of which you are an active member (such as an employee), and your secondary plan is the one of which you are an inactive member (such as a retiree).

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

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

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

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

4. Filing COB Claims

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

a) Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.
b) Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
c) If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.
d) Make sure the provider's name and complete address are on your receipts. If the provider is in Michigan, include the provider's Blue Cross Blue Shield of Michigan identification number (PIN). If the provider is located out of Michigan, include the provider's tax ID number.

Send these items to:

COB Department, Mail Code #610J
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

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

5. Updating COB Information – Your Responsibility

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

B. Subrogation

Your medical plan includes a provision called "Subrogation." If you file a lawsuit or an insurance claim with another carrier, or if there is a settlement with another carrier for which your medical plan had paid for services incurred for which the other carrier is deemed responsible, subrogation allows this Fund and/or BCBSM to hold the other carrier responsible for payment of medical expenses related to the injury. Under the terms of your Plan, the Fund and/or BCBSM may also recover excess payments, if any, which become due to you, your Spouse and/or your dependent or beneficiary.

C. No-Fault Auto Insurance, Motorcycle Insurance and BCBSM Coverage

1. No-Fault Auto Insurance and BCBSM Coverage

The Fund ***does not provide you and/or your eligible family members with any medical coverage for Motor Vehicle related accidents or incidents.*** The Fund will totally and completely exclude coverage for any claim arising out of an auto or other vehicular related accident or incident. "Vehicle" includes all usual forms of transportation on public highways such as vans, pickup trucks, etc.

To make certain that you have medical coverage if you have a vehicular accident/incident, you should check with your automobile insurance agent and/or insurance carrier to make sure that you are covered under your automobile policy "first and completely" for any claim arising out of a vehicular related accident or incident and that you don't require other vehicle/related insurance.

You should inform your agent or carrier that the Fund excludes such coverage from its Schedule of Benefits.

Under the Michigan No-Fault law, effective July 2, 2020, the Fund is not "qualified health coverage". This is Fund information that you will need to make your auto insurance decisions regarding Personal Injury Protection (PIP) coverage.

2. Motorcycle Accidents/Incidents and BCBSM Coverage

The Fund does not provide you and/or your eligible family members with any medical coverage for any Motorcycle related accidents or incidents. You should discuss this information concerning your lack of health care coverage with your motorcycle insurance agent and/or carrier.

SECTION 11: PRIVACY OF HEALTH INFORMATION

A Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's Privacy Notice, distributed to all Plan participants and dependents, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information. This Notice is effective as of August 1, 2018. If you have any questions, contact Privacy Officer at Laborers' Metropolitan Detroit Health Care Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275, or (517) 321-7502, (800) 228-0048, or fax (517) 321-7508, or e-mail to PrivacyOfficer@tici.com.

Privacy Notice

A. Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

1. Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication

- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

2. Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

3. Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

B. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- **You can complain if you feel we have violated your rights by contacting Privacy Officer at Laborers' Metropolitan Detroit Health Care Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275, or (517) 321-7502, (800) 228-0048, or fax (517) 321-7508, or PrivacyOfficer@tici.com.**
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.**
- We will not retaliate against you for filing a complaint.

C. Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

D. Our Uses and Disclosures

1. How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

2. How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease

- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director upon the death of an individual.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:

    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

E. Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

SECTION 12: FEDERAL MANDATED NOTICES

A. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Under MHPAEA, group health plans generally may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans to ensure that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

B. Newborns and Mothers Health Protection Act

Your health plan may not, under Federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the mother's or the newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, no pre-authorization from your health plan or the group health insurance insurer is needed for a stay of up to forty-eight (48) hours (or ninety-six (96) hours.

C. Women's Health and Cancer Rights Act

The medical options provide benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This Federal law states that group health plans provide medical and surgical benefits for mastectomy and must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the Plan will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of mastectomy, including lymphedema.

Benefits will be provided as they would for any other surgical expense.

D. Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 requires that group health plans, like the Plan, recognize and comply with "Qualified Medical Child Support Orders." Below are the Fund's procedures 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 and 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 ERISA as amended and any applicable regulation and administration actions by agencies charged to enforce Section 609. Those criteria include:

- 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 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.
- Creation, assignment or recognition of the right of an alternate recipient to receive Fund benefits to which a participant or a beneficiary is entitled.
- Whether the alternate recipient is a child of the participant or a child adopted by or placed for adoption with a participant.
- 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.
- 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.
- Identification of the period for which the order applies.
- Identification of the Fund as the Plan to which the order supplies.
- Certification that the order does not require the Fund to provide benefits or a form of benefits other than one provided by the Plan, 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.

SECTION 13: BLUE CROSS BLUE SHIELD OF MICHIGAN

A. Member Handbook

This Member Handbook will help you and your family to understand extra details of your Blue Cross Blue Shield of Michigan (BCBSM) health care program. By being well informed, you'll have the confidence and security of knowing that health care coverage is available when you need it.

This guide gives you an overview about your ID card, Explanation of Benefit (EOB) forms, website information and other important phone numbers.

You can also find this information online, along with detailed benefit information, by doing the following:

- Visit www.bcbsm.com and click *Login*
- Register to create your personal account

If you have technical difficulties in registering, please call BCBSM's Web Support at **1-888-417-3479 for assistance**.

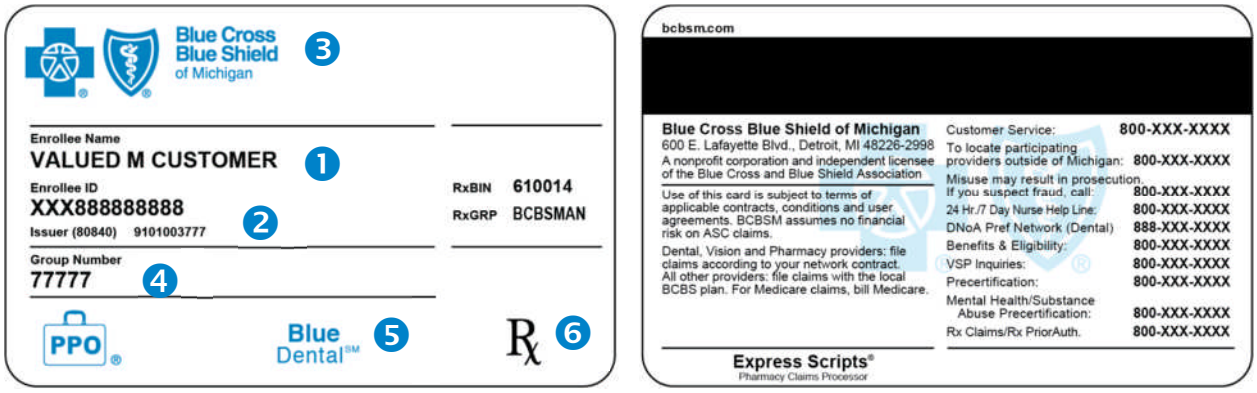
B. Your BCBSM Member ID Card

Once you are enrolled, you'll receive a BCBSM ID card (sample below) which contains the following:

1	**Enrollee name**: The contract holder's name
2	**Enrollee ID:** The contract holder's assigned contract number, which allows health care providers to identify you and your benefits
3	**Issuer:** Identifies you as a Michigan Blue Cross member out-of-state providers
4	Group Number: Identifies your employer group
5 & 6	These icons are present if your coverage includes dental and/or prescription drugs

Customer service phone numbers for you and your providers are located on the back of your member ID card (sample below).

Sample card front **Sample card back**



C. About Your Member ID Card

Only you, your Spouse and/or your Eligible Dependent(s) may use the cards issued to you. Lending your card is illegal and subject to possible fraud investigation and termination of coverage. Call BCBSM and inform them if your card is lost or stolen. Your provider can call BCBSM to verify coverage until you receive your new cards.

If you need additional ID cards:

- Visit www.bcbsm.com and log in

- Click Get an ID card

You can also call the Customer Service number that is on the back of your ID card or you can call your Fund Office at **(800) 228-0048.**

D. Mobile App and Website

BCBSM's mobile app and website provide resources to help you access information and make informed decisions from the convenience of your computer and phone.

Here are some of BCBSM's site and mobile app features:

- **Benefit details**: See what your plan covers so you're more informed when you need care.
- **Out-of-pocket costs**: Know how much you've paid towards your out-of-pocket maximums through cost-sharing.
- **Access to pharmacy and drug information** (for members with BCBSM pharmacy coverage): Look up drug prices, see coverage warnings and find lower cost alternatives.
- **View claims and EOBs**: See what providers charged and why before you pay. Quickly filter and search claims by time frame, member, service type or provider.
- **Find a Doctor**: Find a doctor or hospital in your network. Search by location, specialties, quality recognitions and extended office hours. Get GPS–enabled directions.
- **Compare cost estimates**: Compare cost information in real time for health care services.
- **Virtual member ID card**: Show your virtual member ID card to your doctor for verification of coverage. Search BCBSM within the Apple® App Store or Google® Play and download the mobile app today.

How to Create Your Online Account
Once you receive your BCBSM member ID card, you're ready to create your online member account:

1. Go to www.bcbsm.com
2. Click on the *Login* button at the upper right corner of the homepage
3. Click on *Member*
4. At the bottom of the box, click *Register Now*
5. Follow the registration instructions

How to Download the bcbsm.com Mobile App

1. Visit the Apple® App Store or Android Apps on Google® Play
2. Search for "BCBSM"
3. Download the app to your device
4. Register your account using your BCBSM ID card

E. Member Discounts with Blue365

Save Money and Live Healthier with Blue365
Blue Cross members may find savings on a variety of health-related products and services from businesses in Michigan and across the United States. Member discounts with Blue365 offer exclusive deals on things like:

- **Fitness and wellness**: Health magazines, fitness gear and gym memberships
- **Healthy eating**: Cookbooks, cooking classes and weight-loss programs
- **Lifestyle**: Travel and recreation
- **Personal care**: Lasik and eye care services, dental care and hearing aids

Cash In on Discounts
Show your BCBSM member ID card at participating local retailers or use an offer code online to take advantage of these savings. You can view all savings in one place through your member account at **bcbsm.com**.

For a full list of discount offers log in or register at www.bcbsm.com and click *Member Discounts with Blue365* on the right side of your home page. You can also get monthly updates and details about new offers delivered directly to your email inbox. Just log in at www.bcbsm.com and opt-in to receive emails through *Paperless Options* under *Account Settings*.

F. Choosing Your Provider

Looking for a doctor, hospital or other health care professional?
You can choose any health care provider in your network for routine or general care. To assist in your search, visit www.bcbsm.com and click *Find a Doctor*. This will assist you in finding a provider who best matches your needs. With this application you can:

- Enter your preferred location
- Print your search results
- Easily compare providers
- Find out-of-state doctors
- Review specialty, board certification and education information
- Get cost estimates to help you research and compare certain procedures
- Find contact information
- Read a review of a doctor

You can also find a network provider for the following services on BCBSM's website:

- Primary care services (routine exams or general health issues

- Specialty care
- Behavioral care and substance abuse services
- Evening or weekend services
- Services from a doctor who speaks another language
- Services located near you

G. Preventing Fraud

If your provider asks for another form of identification, don't worry. This is one way BCBSM's providers help protect you against unauthorized use of your card.

You can also help prevent fraud by checking your Explanation of Benefit (EOB) Payments form. If you see a discrepancy on your EOB, contact your provider first to see if it's an error. If it's not and you believe it is fraudulent billing or use of your card, call BCBSM's antifraud hot line at (**800) 482-3787**. You can also fill out BCBSM's online Anti-Fraud form or write to:

Anti-Fraud Unit, Mail Code B759
BCBSM
600 E. Lafayette Blvd.
Detroit, MI 48226

When reporting fraud, all phone calls and correspondence are confidential.

KEEPING YOUR HEALTH INFORMATION SECURE
Expect confidentiality regarding your care. BCBSM will adhere to strict internal and external guidelines concerning your personal health information. This includes the use, access and disclosure of all information that is of a confidential nature.

- Visit www.bcbsm.com/importantinfo
- Click on Keeping Your Health Information Secure

H. What You Pay Out-of-Pocket

For details of the amount of out-of-pocket expenses you pay for covered services:

- Visit www.bcbsm.com and log in
- Click *My Coverage* and select either *Medical*, *Prescription Drugs* or *Vision*
- Click What's Covered

If you have to pay for covered services, BCBSM will reimburse you for BCBSM's share of the cost. For more information and for a copy of the form:

- Visit www.bcbsm.com and log in
- Click *Forms*

I. Health Resources

Blue Cross® Health & Wellness
Your health and well-being are important. That's one of the main reasons your health care plan includes Blue Cross Health & Wellness, which helps you get healthy, stay healthy and improve your quality of life if you're living with an illness. This resource offers a 24-Hour Nurse Line that you can call with questions about your health. It also offers an effective disease management program to help you better manage your condition. In addition, if you have a specific health condition, a nurse health coach may contact you by phone or send information to you.

The Blue Cross Health & Wellness website, powered by WebMD®, offers a variety of helpful resources that can help you learn about your health risks and ways to stay healthy or improve your health. The Blue Cross Health & Wellness site includes:

- An easy-to-use online health assessment that gives you an analysis of your personal health risks and what you can do to improve your health
- Digital Health Assistant programs for exercise, nutrition, weight loss, tobacco cessation, stress relief and mental health that help you set goals and make small positive changes
- Health trackers so you can chart your healthy measures over time
- A Device and App Connection Center where you can sync your favorite fitness and medical devices and apps
- Message board exchanges that are professionally monitored
- Interactive programs such as calculators, guides, quizzes, slide shows and more
- Videos, recipes, articles, health encyclopedias and more

To access the Blue Cross Health & Wellness website:

1. Log in or register for www.bcbsm.com
2. Click on the *Health & Wellness* tab to enter the Blue Cross Health & Wellness website. You'll need to register for the website on your first visit.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan by providing health and wellness services.

J. Blue Card® Program

When traveling outside of Michigan, your coverage travels with you. Through the BlueCard program, you can find network and participating providers throughout the U.S. and around the world. And, like network and participating providers in Michigan, you won't have to fill out claim

forms or pay up front for the cost of the service unless it's an out-of-pocket cost such as a deductible, coinsurance and/or copayment, or a noncovered service.

Here are three steps to make the BlueCard program work for you:

1. In an emergency, go directly to the nearest hospital
2. Call **1-800-810-BLUE (2583)**
3. When you arrive at the network or participating provider's office or hospital, present your member ID card. The doctor or hospital will recognize the suitcase logo and know that you're receiving services under the BlueCard program. This means they'll submit claim forms and only bill you for any deductible, coinsurance and/or copay that may be required by your health care plan.

K. Care Away From Home

Within the U.S.
When you're traveling, you're covered through BCBSM's **BlueCard**[SM] program. BlueCard gives Blue Cross members seamless national access to the ninety-two percent (92%) of physicians and ninety-six percent (96%) of hospitals that participate in Blue Cross Blue Shield networks. No matter where you live, work or travel, BCBSM members, through BlueCard, can continue to receive the high-quality care benefits of your plan. Remember, if the doctor or hospital is out-of-network, you could pay higher out-of-pocket costs; i.e., higher deductible, coinsurance and/or copayments.

To find a doctor or hospital outside of Michigan, you can use the *Find a Doctor* search tool at www.bcbsm.com**,** download and log on to our mobile app or call **(800) 810-2583**.

Outside the U.S.
If you're traveling or living outside of the country, Blue Cross Blue Shield Global Core provides members with access to a network of traditional inpatient, outpatient and professional health care providers around the world. The program includes a broad range of medical assistance and claim support services for members traveling or living in countries outside their Home Plan service area. For more information, visit www.bcbsglobalcore.com.

Remember: Show your Blue Cross member ID card to your doctor or health care provider to verify your PPO benefits.

L. Claims Information

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

Filing a Claim
If you receive services from a non-participating or non-network provider, ask the provider if he or she will bill BCBSM for the services. Most providers will submit claims for their patients when asked.

If your provider won't bill BCBSM for you, follow these steps:

- Ask the provider for an itemized statement or receipt with the following information:
  - Name and address of provider
  - Full name of patient
  - Date of service
  - Provider's charge
  - Diagnosis and type of service
- Make a copy of all items for your files and send the originals to BCBSM with the claim form. It's important that you file claims promptly because most services have claims filing limitations. To find the form:
  - Visit www.bcbsm.com and log in
  - Click *Forms*
  - **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.

Payments for services will be made directly to you.

M. Explanation of Benefits (EOB)

Your Explanation of Benefits
After BCBSM processes claims for services you receive, BCBSM will send you an explanation of benefits, which is commonly referred to as an EOB. The EOB isn't a bill. It helps you understand how your benefits were paid. At the top of the EOB, you'll find Blue Cross Blue Shield Customer Service numbers and an address to use for questions.

Receive Your Explanation of Benefits Electronically
Instead of receiving your EOBs in the mail, you can sign up to get them online. BCBSM will notify you by email when a new EOB has been posted. You can view, save or print your EOB statements.

- Visit www.bcbsm.com and log in
- Click Account Settings
- Click Paperless Options

Reading Your EOB
Briefly, your Explanation of Benefits tells you:

- The person who received the services and the date services were provided
- "Claim Summary" includes the providers of the services and payments including the amount saved by using network providers
- "Summary of Deductibles and Out-of-Pocket Maximums" shows your deductible and copayment requirements and a total of all deductibles and copayments paid to date
- "Claim Details" summarizes the Blue Cross payment and shows your balance

If you see an error, contact your provider first. If your provider can't correct the error, call the Customer Service number on your EOB.

N. Customer Service

To call BCBSM, please use the phone number printed on the back of your member ID card. You can also find this number on your EOB form.

BCBSM's Customer Service hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.

You can visit www.bcbsm.com to see if there's a walk-in customer service center near you for personal, face-to-face service.

BCBSM's goal is to provide excellent service. When you call, please be ready to provide BCBSM with your contract number. If you're inquiring about a claim, BCBSM will also need the following information:

- Patient's name
- Provider's name (hospital, doctor, laboratory, other)
- Date of service and type of service (surgery, office call, X-ray, other)
- Provider's charges

Please remember, Blue Cross Blue Shield of Michigan follows strict privacy policies in accordance with state and federal law. You'll find BCBSM's *Protected Health Information and Privacy Forms* at www.bcbsm.com/importantinfo.

O. Language Translation Services

When you call the Customer Service number on the back of your Blue Cross member ID card, you can request language assistance.

Assistance Speaking Your Language
If you or someone you're helping needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك
دون أية تكلفة. للتحدث
إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話。

ﺇﺫﺍ ﻛﻨﺖ ﺃﻧﺖ ﺃﻭ ﺷﺨﺺ ﺁﺧﺮ ﺗﺴﺎﻋﺪﻩ ﺑﺤﺎﺟﺔ ﻟﻤﺴﺎﻋﺪﺓ، ﻓﻠﺪﻳﻚ ﺍﻟﺤﻖ ﻓﻲ ﺍﻟﺤﺼﻮﻝ ﻋﻠﻰ ﺍﻟﻤﺴﺎﻋﺪﺓ ﻭﺍﻟﻤﻌﻠﻮﻣﺎﺕ ﺍﻟﻀﺮﻭﺭﻳﺔ ﺑﻠﻐﺘﻚ
ﺩﻭﻥ ﺃﻳﺔ ﺗﻜﻠﻔﺔ. ﻟﻠﺘﺤﺪﺙ
ﺇﻟﻰ ﻣﺘﺮﺟﻢ ﺍﺗﺼﻞ ﺑﺮﻗﻢ ﺧﺪﻣﺔ ﺍﻟﻌﻤﻼء ﺍﻟﻤﻮﺟﻮﺩ ﻋﻠﻰ ﻇﻬﺮ ﺑﻄﺎﻗﺘﻚ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오.

যদি আপনার, বা আপদন সাহাযয করছেন এমন কাছরা, সাহাযয প্রছ াজন হ , তাহছে আপনার ভাষা দবনামূছেয সাহাযয ও তথ্য পাও ার অদিকার আপনার রছ ছে। ককাছনা একজন কিাভাষীর সাছথ্ কথ্া বেছত, আপনার কাছডের কপেছন কিও া গ্রাহক সহা তা নম্বছর কে করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

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

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

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

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

Blue Cross Blue Shield and Blue Care Network of Michigan are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

SECTION 14: INTRODUCTION TO PLAN BENEFITS

Your health care benefits are administered through Blue Cross Blue Shield of Michigan (BCBSM). The following is intended as an easy-to-read summary of benefits and provides only a general overview. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on the BCBSM approved amount, less any deductible, coinsurance and/or copayment that may be required. For a detailed description of benefits, please see the applicable BCBSM certificates, riders and plan modifications (called the Plan Documents). If there is a discrepancy between this benefit summary and the Plan Documents, the Plan Documents will control.

SECTION 15: PREVENTIVE HEALTH CARE PROGRAM

This Plan has a Preventive Health Care Program (Program). It includes an examination and comprehensive diagnostic services for you and your Spouse with an emphasis on prevention and

early detection of, and referral for treatment of occupationally related diseases. This Program provides for one (1) preventive health care examination, at no cost to you, once each consecutive twelve (12) month period.

There are facilities within Providence Corporate Health Services who participate in this Program.

If you are interested in participating in this Program, contact the Fund Office for verification of your eligibility. If you're eligible for this examination, the Fund Office will send you a voucher, which you must present at the examination.

Once you've received your voucher, contact one of the participating providers to set up your examination date and time (the addresses and telephone numbers of the participating facilities are on the voucher). The Plan may offer incentives, such as credit towards self-payments and/or claims copayments, for those participants who receive a physical examination under this Preventive Health Care Program from one of the Fund's participating providers.

SECTION 16: COMPREHENSIVE MAJOR MEDICAL–PPO (CMM-PPO) MEDICAL BENEFITS

These benefits are for Active/Active Self-Pay Employees (and eligible family members), Early Retirees and non-Medicare Totally & Permanently Disabled Retirees, Surviving Spouses and Eligible Dependent(s).

A. Preauthorization for Select Services

Services listed in this benefit summary are covered when provided in accordance with BCBSM policies and, when required, are preauthorized or approved by BCBSM. The following services require your provider to obtain approval before receiving these services – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, residential psychiatric facilities, rehabilitation therapy and applied behavioral analyses. Detailed information can be found at www.bcbsm.com/important.info.

B. Pricing Information

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. To assist the BCBSM customer service representative in answering your question, you should be prepared to provide both the procedure and diagnostic code for the service in question. Your provider also has this information available upon request.

C. Preauthorization for Specialty Pharmaceuticals

Select specialty pharmaceuticals may require preauthorization when received in locations such as a physician's office, clinic, outpatient facility or through a home health care provider. Specialty pharmaceuticals are biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer. BCBSM determines which specific drug claims are payable. Contact BCBSM for a comprehensive list of specialty drugs by calling the number on the back of your BCBSM ID cards.

D. CMM-PPO In-Network Providers

Providers who have contracted with BCBSM's PPO program are termed "**In-network**" or "**Participating**" PPO providers. In other words, these providers are part of the BCBSM PPO network. If you use the services of a PPO network provider, you will be responsible only for deductibles, coinsurance and/or copayments as applicable for approved services.

E. CMM-PPO Out-Of-Network Providers

Providers who have not contracted with BCBSM's PPO program are considered either "**Out-of-network**" or "**Non-participating**" providers. An Out-of-network provider is a provider who has not contracted with BCBSM as a PPO provider but has contracted with BCBSM as a "**Traditional**" provider. If you choose an "**Out-of-network**" provider for services, you will be responsible for only the **higher** applicable deductibles, coinsurance and/or copayments as long as the **"Out-of-network"** provider is part of BCBSM's **Traditional** network.

Providers who are not contracted with BCBSM as either a PPO or Traditional provider are considered "Non-participating" providers. "Non-participating" providers may bill you for applicable deductibles, coinsurance and/or copayments and they can also bill you for balances that are greater than BCBSM's approved amount. These balances could be substantial.

If a PPO provider "refers" you **Out-of-network** to a BCBSM **Traditional** participating provider, you will be liable only for **In-network** applicable deductibles, coinsurance and/or copayments. **A referral must be requested by your provider prior to your service.** If you are referred to a provider who does not participate in BCBSM's Traditional or PPO Network, you will be responsible for applicable deductibles, coinsurance and/or copayments **and** any costs billed by the provider that are greater than BCBSM's approved amount. These balances can be substantial.

Note: Approved services received 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.

Services received at a non-participating facility, clinic or freestanding facility other than emergency services are not covered.

F. Claims Incurred in Foreign Countries

Claims incurred in foreign countries are covered by the Plan, subject to all the limitations and exclusions of the Plan. Additional time is required to process claims submitted from foreign countries. You should contact the BCBSM customer service department or the Fund Office for further information or assistance.

G. Member Cost Sharing Requirements

Deductibles, Coinsurance, Copayments and Dollar Maximums	**In-Network**	**Out-of-Network**
Deductibles – Calendar Year	**$0** – (there is no deductible)	**$0** – (there is no deductible)
Percent Coinsurance	**20%** of the approved amount for covered service	**30%** of the approved amount for covered services
Fixed Dollar Copayments	**$0** – (there are no fixed dollar copayments)	**$0** – (there are no fixed dollar copayments)
Annual Coinsurance Dollar Maximums – Calendar Year **Note:** Coinsurance for private duty nursing does not apply to the annual coinsurance maximum	**$1,000 Per Family** (In-network coinsurance amounts **do not** count towards the Out-of-network coinsurance maximums)	**$1,000 Per Family** (Out-of-network coinsurance amounts **do not** count towards the In-network coinsurance maximums)
Out-of-Pocket Maximums – Calendar year 2021 Note: Includes applicable deductible, coinsurance and copayment amounts for covered services including prescription drug cost sharing	**$8,150 Per Individual/ $16,300 Family** (In-network cost sharing amounts **do not** count towards the Out-of-network, Out-of-pocket maximums) **Note:** Out-of-pocket maximums may change annually	**$8,150 Per Individual/ $16,300 Per Family** (Out-of-network cost sharing amounts **do not** count towards the In-network, Out-of-pocket maximums) **Note:** Out-of-pocket maximums may change annually.
Lifetime dollar maximum	None	

H. Plan Covered Services

Preventive Care Services	In-Network	Out-of-Network
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
	One routine per individual per calendar year	
Gynecological exam	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
	One routine per individual per calendar year	
Pap smear screening – laboratory and pathology services	**100%** of the approved amount (no deductible/ coinsurance/copayment) **Note:** Subsequent medically necessary pap tests performed during the same calendar year are subject to your percent coinsurance	**70%** of the approved amount (no deductible/ copayment) **Note:** Out-of-network pap tests are subject to your percent coinsurance whether routine or medically necessary
	One routine per individual per calendar year	
Voluntary sterilization for females	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
Contraceptive injections	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)

Preventive Care Services	In-Network	Out-of-Network
Well-baby and child-care visits	**100%** of the approved amount (no deductible/ coinsurance/copayment) • 8 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 individual per calendar year under the health maintenance exam benefit	**70%** of the approved amount (no deductible/ copayment)
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 (PPACA)	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
Fecal occult blood screening	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
	One routine per individual per calendar year	
Flexible sigmoidoscopy exam	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
	One routine per individual per calendar year	
Prostate specific antigen (PSA) screening	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
	One routine per individual per calendar year	

Preventive Care Services	**In-Network**	**Out-of-Network**
Routine mammogram and related reading	**100%** of the approved amount (no deductible/ coinsurance/copayment) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your percent coinsurance	**70%** of the approved amount (no deductible/copayment) **Note:** Out-of-network mammograms are subject to your percent coinsurance whether routine or medically necessary
	One routine screening per individual per calendar year	
Colonoscopy – routine and/or medically necessary	**100%** of the approved amount (no deductible/ coinsurance/copayment) for the first billed colonoscopy in a calendar year **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your percent coinsurance	**70%** of approved amount (no deductible/ copayment) **Note:** Out-of-network colonoscopies are subject to your percent coinsurance whether routine or medically necessary
	One routine per individual per calendar year	
CA-125 Screening	**100%** of approved amount (no deductible/ coinsurance/copayment)	**70%** of approved amount (no deductible/ copayment)

Physician Office Services	**In-Network**	**Out-of-Network**
Office visits	**80%** of the approved amount (no deductible/ copayment)	**70%** of approved amount (no deductible/ copayment)
Outpatient and home medical care visits	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)
Office consultations	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)

Urgent care visits	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)

Emergency Medical Care	**In-Network**	**Out-of-Network**
Urgent Care Clinic (Professional Services)	**80%** of the approved amount (no deductible/coinsurance/ copayment)	**80%** of the approved amount (no deductible/ copayment)
Physician's office	**80%** of the approved amount (no deductible/coinsurance/ copayment)	**80%** of the approved amount (no deductible/ copayment)
Hospital Emergency Room	**80%** of the approved amount (no deductible/copayment)	**80%** of the approved amount (no deductible/ copayment)

Diagnostic Services	**In-Network**	**Out-of-Network**
Laboratory and pathology services	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)
Diagnostic tests and x-rays	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)
Therapeutic radiology	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)

Maternity Services – Provided by a Physician or Certified Nurse Midwife	**In-Network**	**Out-of-Network**
Prenatal care	**100%** of the approved amount (no deductible/ coinsurance/copayment)	**70%** of the approved amount (no deductible/ copayment)
Postnatal care	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)
Delivery and nursery care	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/ copayment)

Hospital Care	In-Network	Out-of-Network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note: <u>Non-emergency</u> services must be rendered in a participating hospital.**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
	Unlimited Days	
Inpatient consultations	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
Chemotherapy	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)

Alternatives to Hospital Care	In-Network	Out-of-Network
Skilled nursing care **Note: Services must be rendered in a participating skilled nursing facility.**	**80%** of approved amount (no deductible/copayment)	
Hospice care **Note: Services must be provided through a participating hospice program.**	**100%** (no deductible/coinsurance/copayment) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods; limited to a dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member may transition into individual case management)	
Home health care **Note: Services must be provided by a participating home health care agency.**	**80%** of the approved amount (no deductible/copayment)	
Home infusion therapy **Note: Services must be provided by a participating home infusion therapy provider or a participating**	**80%** of the approved amount (no deductible/copayment)	

freestanding ambulatory infusion center (AIC). Some drugs may require preauthorization.	

Surgical Services	In-Network	Out-of-Network
Surgery – includes related surgical services. **Note: Services must be provided in a participating ambulatory surgical facility for facility costs to be covered**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
Pre-surgical consultations	**80%** of the approved amount (no deductible/coinsurance/ copayment)	**70%** of the approved amount (no deductible/ copayment)
Voluntary sterilization for males **Note: See "Preventive Care Services" section for voluntary sterilizations for females**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
Voluntary Abortions **Note: Limited to one per dependent child per lifetime. No limit for subscriber or Spouse.**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)

Human Organ Transplants	In-Network	Out-of-Network
Specified human organ transplants **Note: Covered in designated facilities only <u>and</u> when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)**	**100%** of the approved amount (no deductible/ coinsurance/copayment)	

Bone Marrow Transplants **Note: Must be coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
Specified oncology clinical trials **Note: Clinical trials are covered in compliance with PPACA**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
Kidney, cornea and skin transplants	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount(no deductible/ copayment)
Mental Health Care and Substance Abuse Treatment	**In-Network**	**Out-of-Network**
Inpatient mental health care and inpatient substance abuse services **Note**: **Services must be provided in a participating facility** **Preauthorization is required.**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
Outpatient mental health care – facility and clinic **Note: Services must be provided in a participating facility/clinic**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment) **Note**: In-network cost-sharing will apply if there is not a PPO network
Residential psychiatric treatment facility **Note: Services must be provided in a residential**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)

psychiatric treatment facility **Preauthorization is required.**		
Mental health and substance abuse physician services	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)

Mental Health Care and Substance Abuse Treatment	**In-Network**	**Out-of-Network**
Outpatient substance abuse treatment facility **Note**: **Services must be provided in a participating facility**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment) **Note**: In-network cost-sharing will apply if there is not a PPO network
Autism Spectrum Disorders, Diagnoses and Treatment	**In-Network**	**Out-of-Network**
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age eighteen (18) when preauthorized **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.**	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/copayment)
Outpatient physical therapy, speech therapy, occupational therapy, nutritional	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/copayment)

counseling for autism spectrum disorder		
Other covered services, including mental health services for autism spectrum disorder	**80%** of the approved amount (no deductible/ copayment)	**70%** of the approved amount (no deductible/copayment)

Other Covered Services	**In-Network**	**Out-of-Network**
Outpatient Diabetes Management Program (ODMP) **Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount when rendered by an In-network provider**	**100%** of the approved amount (no deductible /coinsurance/ copayment) for diabetes self-management training by a **participating** provider **80%** of the approved amount (no deductible/copayment) for diabetes medical supplies	**70%** of the approved amount (no deductible/copayment) for diabetes self-management training and for diabetes medical supplies
Allergy testing and therapy	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible)
Chiropractic spinal manipulation and osteopathic manipulative therapy services	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
	Limited to a maximum of **12** visits per individual per calendar year combined In-network and Out-of-network	
Outpatient physical, speech and occupational therapy **Note: Services at non-participating, outpatient physical therapy facilities and non-participating freestanding facilities are not covered**	**80%** of the approved amount (no deductible/copayment)	**70%** of the approved amount (no deductible/ copayment)
Durable medical equipment (DME)	**80%** of the approved amount (no deductible/copayment)	

Note: DME items required under the PPACA are covered at 100% of the approved amount with no In-network cost-sharing when rendered by a network provider. For a list of covered DME items required under PPACA, call BCBSM	
Prosthetic and orthotic appliances	**80%** of the approved amount (no deductible/copayment)

Other Covered Services	In-Network	Out-of-Network
Private duty nursing **Note: Must be preauthorized by BCBSM**	**80%** of the approved amount (no deductible/copayment)	
Ambulance services	**80%** of the approved amount (no deductible/copayment)	

I. Exclusions And Limitations For Medical Benefits

Note: The categories listed below may not be all inclusive and are subject to your certificates, riders and plan modifications.

EXCLUSIONS

No-Fault Auto Insurance
If you, your Spouse and/or your Eligible Dependent(s) are involved in a motor vehicle accident or incident, **BCBSM will not pay for services related to an injury which is a direct or indirect result of an automobile accident or incident.** This applies whether or not you have no-fault automobile insurance.

Under Michigan No-Fault Law (effective July 2, 2020), this Plan is not "qualified health coverage." It is important that you discuss this with your auto insurance company, as this Plan does not provide health care coverage in the event of a motor vehicle accident or incident. See Section 9(E) for more detail.

NOTE: This exclusion applies to **all** vehicle related accident or incidents such as vans, trucks, motorcycles, etc. Services related to an injury resulting from any vehicle accident are not covered by this **Plan**.

Motorcycle Insurance
This Plan **does not** cover injuries or services resulting from motorcycle incidents or accidents. Contact your insurance agent or carrier to discuss your insurance options.

LIMITATIONS

Hospital and Facility Care Inpatient Services Non-Payable

- Services received in a non-participating hospital or facility except emergency services.
- Services that may be medically necessary but can be provided safely in an outpatient office location.
- Custodial care or rest therapy.
- Psychological tests if used as part of, or in connection with, vocational guidance, training or counseling.
- 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.

Hospital Admissions Non-Payable

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 provided by a non-participating hospital.
- Services for mental health care that is beyond the period required to evaluate or diagnose mental health deficiencies 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 except for emergency services (see Other Providers Non-Payable below)
- 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 provided by a non-participating home health care agency.
- 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.
- Cardiac or pulmonary rehabilitation services that require less than intensive monitoring (i.e., through the use of EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable.
- Experimental or investigational items, devices or the service itself.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Other Providers Non-Payable

- 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.
- Non-participating end stage renal disease facilities.
- Services performed by a non-participating home health care provider.
- Services provided at a non-participating skilled nursing facility.

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

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. (See Vision benefits for payable vision services.)
- 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.

Physician Services Non-Payable (continued)

- 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 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 health care benefits.
- 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.
- Gender reassignment services that are considered by BCBSM to be cosmetic or treatment that is experimental or investigational.
- Custodial and non-skilled care.
- Services not listed in your certificate, rider or plan modification 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.
- Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners.
- Exercise and hygienic equipment such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats.
- Sauna baths, elevators, experimental equipment.

Time Limit for Filing Pay-Provider Medical Claims

- BCBSM will not pay medical claims filed after the timeframe set out in the treating provider's participation agreement with BCBSM.
- BCBSM's time limit for submitting a claim for payment for a "Non-participating" provider is twenty-four (24) months.

J. Federal No Surprises Act – Your Rights and Protections Against Surprise Medical Bills

Effective January 1, 2022, you cannot be balance billed when you receive emergency care or are treated at a nonparticipating provider at a participating hospital or ambulatory center.

Generally, balance billing is when you receive services from a provider or facility, and you may owe certain out-of-pocket costs for the difference between what the Plan agrees to pay, and the full amount charged for the service if the provider or health care facility does not participate with this Plan.

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **cannot** be balance billed for these emergency services.

This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain Services At An In-network Hospital Or Ambulatory Surgical Center

When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the Plan's in-network cost-sharing amount.

This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections. You are never required to give up your protections from balance billing.

If you believe you have been incorrectly billed, contact the No Surprises Help Desk at (800) 985-3059.

SECTION 17: PRESCRIPTION DRUG BENEFITS

These benefits are for Active/Active Self-Pay Employees (and eligible family members), Early Retirees and non-Medicare Totally & Permanently Disabled Retirees, Surviving Spouses and Eligible Dependent(s).

A. OptumRx®

Effective January 1, 2022, OptumRx® is providing pharmacy benefit services for you and your family members. Your BCBSM ID card identifies that you have a prescription drug program. Prescription Drug coverage is based on the BCBSM Custom Formulary and subject to Prior Authorization, Step-Therapy and Quantity Limits. For information, assistance, mail order forms, etc., access BCBSM's website at www.bcbsm.com/pharmacy or call the number on the back of your BCBSM ID card.

B. Prescription Drugs Day Supply

Your pharmacy program allows for a thirty (30) day supply of a covered prescription drug. BCBSM may make exceptions for prescription drugs whose minimal package size prevents a thirty (30) day supply from being dispensed.

C. Ninety (90) Day Mail Order and Retail Prescription Drug Program

In addition to a thirty (30) day supply for a prescription, your Plan allows for a ninety (90) day supply through either your BCBSM ninety (90) day retail pharmacy program or ninety (90) day mail order program for **non-specialty** drugs (see additional information on **specialty** drugs below.) Your physician **must** write your prescription for ninety (90) days.

D. Specialty Pharmaceutical Drugs

Select 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 and monitoring. Most "**In-network**" retail pharmacies can dispense specialty drugs. You should, however, check with your local pharmacy for availability and assistance.

BCBSM will **not** pay for more than a thirty (30) day supply of a covered prescription drug that BCBSM defines as a "**specialty pharmaceutical drug**" even if the drug is obtained from a ninety (90) day retail network pharmacy or mail-order provider. BCBSM may make exceptions if a member requires more than a thirty (30) day supply.

BCBSM also reserves the right to limit the quantity for certain select specialty drugs to no more than a fifteen (15) day supply for an initial fill. Any applicable copayment/coinsurance will be reduced by one-half (1/2) for a prescription that has been reduced to a fifteen (15) day supply. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable copayment/coinsurance requirement for a thirty (30) day) supply.

AllianceRX Walgreens Prime is also available to assist for **mail order** prescriptions for **specialty pharmaceutical drugs**. If you have questions, or require assistance, call AllianceRx Walgreens Prime customer service at **866-515-1355**. Note that AllianceRx Walgreens Prime provides mail order services **only for specialty drugs**. Other mail order prescriptions should be sent to OptumRx®.

E. Controlled Substance Prescription Drugs

BCBSM may limit the initial fill of a select controlled substance prescription drug (such as hydromorphone, oxycodone, etc.) to a five (5) day supply. You will be responsible for your applicable copayment/coinsurance or the cost of the prescription drug, whichever is lower, for the five (5) day supply. The remaining twenty-five (25) day supply can be refilled (if needed) after the initial five (5) day) supply. You will be responsible for your copayment/coinsurance or the cost of the prescription drug, whichever is lower, for the remaining twenty-five (25) day supply. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable copayment/coinsurance requirement for a thirty-day (30-day). A list of select controlled substance prescriptions affected by this requirement is available online at www.bcbsm.com/pharmacy.

Note: BCBSM will not pay for prescription drugs obtained from an out-of-network mail order provider, including internet providers**.**

F. Covered Services and Cost Sharing Requirements

Your prescription drug copayments and/or coinsurance amounts, including mail order copayment and/or coinsurance amounts, are subject to the same annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your out-of-pocket maximum.

- Any difference between the Maximum Allowable Cost and the BCBSM approved amount for a covered brand name drug that is your responsibility
- The twenty-five percent (25%) member liability for covered drugs obtained from an out-of-network pharmacy
- Costs for prescription drugs that are not a covered benefit.

Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Note the Plan also includes a Prescription Drug Manufacturer Coupon Assistance Program. See Section I. for more details.

COVERED SERVICES AND COST SHARING REQUIREMENTS

Benefits		**90-Day retail network pharmacy**	**In-network mail order provider**	**In-network pharmacy (not part of the 90-Day retail network)**	**Out-of-network pharmacy**
Tier 1 – Generic or select prescribed over-the-counter drugs*	1-30 day supply	**$20** copayment	**$20** copayment	**$20** copayment	**$20** copayment plus an additional **25%** of the approved amount
	31-83 day supply	**No coverage**	**$40** copayment	**No coverage**	**No coverage**
	84-90 day period	**$40** copayment	**$40** copayment	**No coverage**	**No coverage**
Tier 2 – Preferred brand-name drugs	1-30 day supply	**$60** copayment	**$60** copayment	**$60** copayment	**$60** copayment plus an additional **25%** of the approved amount
	31-83 day supply	**No coverage**	**$120** copayment	**No coverage**	**No coverage**
	84-90 day supply	**$120** copayment	**$120** copayment	**No coverage**	**No coverage**
Tier 3 – Non-preferred	1-30 day supply	**$100** copayment	**$100** copayment	**$100** copayment	**$100** copayment plus an additional **25%** of the

Benefits		90-Day retail network pharmacy	In-network mail order provider	In-network pharmacy (not part of the 90-Day retail network)	Out-of-network pharmacy
brand-name drugs					approved amount
	31-83 day supply	**No coverage**	**$200** copayment	**No coverage**	**No coverage**
	84-90 day supply	**$200** copayment	**$200** copayment	**No coverage**	**No coverage**
Tier 4 – Generic and preferred brand-name specialty drugs	1-30 day supply	**20%** of the approved amount but not more than **$200**	**20%** of the approved amount but not more than **$200**	**20%** of the approved amount but not more than **$200**	**20%** of the approved amount but not more than **$200** amount plus **25%** of the approved amount
	31-83 day supply	**No coverage**	**No coverage**	**No coverage**	**No coverage**
	84-90 day supply	**No coverage**	**No coverage**	**No coverage**	**No coverage**
Tier 5 - Non-preferred brand-name specialty drugs	1-30 day supply	**25%** of the approved amount but not more than **$300**	**25%** of the approved amount but not more than **$300**	**25%** of the approved amount but not more than **$300**	**25%** of the approved amount but not more than **$300** plus **25%** of the approved amount
	31-83 day supply	**No coverage**	**No coverage**	**No coverage**	**No coverage**
	84-90 day supply	**No coverage**	**No coverage**	**No coverage**	**No coverage**

COVERED SERVICES

Benefits	**90-Day retail network pharmacy**	**In-network mail order provider**	**In-network pharmacy (not part of the 90-Day retail network)**	**Out-of-network pharmacy**
FDA-approved drugs	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**75%** of the approved amount less plan copayment/ coinsurance
Prescribed over-the counter drugs – when covered by BCBSM	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**75%** of the approved amount less plan copayment/ coinsurance
State-controlled drugs	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**75%** of the approved amount less plan copayment/ coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	**100%** of the approved amount	**100%** of the approved amount	**100%** of the approved amount	**75%** of the approved amount

Benefits	90-Day retail network pharmacy	In-network mail order provider	In-network pharmacy (not part of the 90-Day retail network)	Out-of-network pharmacy
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**75%** of the approved amount less plan copayment/ coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of PPACA	**100%** of the approved amount	Not Covered	**100%** of the approved amount	**75%** of the approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medications (non-self-administered	**100%** of the approved amount	**100%** of the approved amount	**100%** of the approved amount	**75%** of the approved amount

Benefits	90-Day retail network pharmacy	In-network mail order provider	In-network pharmacy (not part of the 90-Day retail network)	Out-of-network pharmacy
drugs are not covered)				
Other FDA-approved **brand** name prescription contraceptive medications (non-self-administered drugs are not covered)	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**100%** of the approved amount less plan copayment/ coinsurance	**75%** of the approved amount less plan copayment/ coinsurance
Insulin or other covered injectable legend drugs dispensed with disposable needles and syringes **Note:** Needles and syringes do not require a separate copayment or coinsurance	**100%** of the approved amount less plan copayment/ coinsurance for insulin or other covered injectable legend drug	**100%** of the approved amount less plan copayment/ coinsurance for insulin or other covered injectable legend drug	**100%** of the approved amount less plan copayment/ coinsurance for insulin or other covered injectable legend drug	**75%** of the approved amount less plan copayment/ coinsurance for insulin or other covered injectable legend drug

G. Features of Your Prescription Drug Plan

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

	• **Tier 1 (generic drugs)** – Tier 1 includes most 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. These drugs require the lowest copayment/coinsurance, making them the most cost-effective option for the treatment. **Generic specialty drugs are in Tier 4.** • **Tier 2 (preferred brand-name drugs)** – Tier 2 includes preferred, non-specialty brand-name drugs. Preferred brand name drugs are more expensive than generics and require a higher copayment/coinsurance. • **Tier 3 (non-preferred brand-name drugs)** – Tier 3 contains non-specialty, non-preferred brand name drugs for which there is either a generic alternative or a more cost-effective, preferred brand-name drug available. These drugs require a higher copayment/coinsurance than Tier 1 or 2. • **Tier 4 (generic and preferred brand-name specialty drugs)** - Tier 4 includes covered specialty drugs, both generic and brand name, that are used to treat difficult health conditions. These drugs have the lowest specialty drug copayment/coinsurance. • **Tier 5 (non-preferred, brand-name specialty drugs)** - Tier 5 includes non-preferred, specialty drugs that are used to treat difficult health conditions. These drugs have the highest specialty drug copayment/coinsurance.
Prior Authorization/Step Therapy	**Prior Authorization** is a process that requires a physician to obtain approval from BCBSM before select prescription drugs (as identified by BCBSM) will be covered. **Step therapy**, an initial step in the **Prior Authorization** process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. Details about which drugs require prior authorization or step therapy are available online at **www.bcbsm.com/pharmacy.**
Mandatory maximum allowable cost (MAC) drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, **you will be required** to 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 copayment/coinsurance regardless of whether you or your physician requests the brand-name drug. **Exception**: If your physician requests and **receives authorization** from BCBSM for a brand-name drug for which a generic equivalent is available and writes "**Dispense as Written**" or "**DAW**" on your prescription, you pay only your applicable copayment/coinsurance. **Note**: **The MAC difference will not be applied toward any annual deductible, annual coinsurance maximum or annual out-of-pocket maximum.**
Quantity limits for selected drugs	BCBSM may limit the quantity of select medications. These limits are consistent with FDA approved dosing guidelines.
Drug interchange and generic Copayment/Coinsurance Waiver Program	BCBSM's drug interchange and generic copayment/coinsurance waiver program encourages physicians to prescribe less-costly generic equivalent drugs. If your physician rewrites your prescription for the recommended generic or over-the-counter (OTC) alternate drug, you will only have to pay the applicable generic copayment/coinsurance percentage. In select cases, BCBSM may waive the initial copayment/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Elective lifestyle drugs	Benefits are excluded for elective lifestyle drugs. **Note: Elective lifestyle drugs are lifestyle drugs that treat conditions such as sexual impotency, infertility or help in weight loss. They are not drugs that are designed to treat acute or chronic illnesses or are prescribed for medical conditions that have demonstrable physical harm if not treated. Smoking cessation drugs are <u>not</u> considered elective lifestyle drugs and <u>are</u> a payable benefit. BCBSM determines when a drug is an elective drug.**
Off-label/ High-cost specialty review programs	BCBSM's specialty review program does <u>not</u> allow coverage for drugs prescribed for uses other than those approved by the FDA. This program requires a prior authorization review of high cost specialty drugs.
Dose optimization	BCBSM may discuss with your physician the use of specific prescription drugs in once-daily dosage regimens as opposed to using lower multiple doses of the same drug.

Quantity Limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

H. Exclusions and Limitations

Note: This list may not be all inclusive and is subject to your certificate, riders and plan modifications.

- 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.
- Prescription 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.
- Administration of covered drugs; e.g., injections.
- Non-self-administered injectable drugs (except for select immunization vaccines).
- Any vaccine given solely to resist infectious diseases (except for select immunization vaccines).
- More than a thirty-day (30-day) supply of a covered drug. Exceptions may be made for certain maintenance drugs, for drugs whose minimal package size prevents a 30-day supply from being dispensed; e.g., inhalers or drugs approved through a ninety-day (90-day) retail or mail order program.
- More than a thirty-day (30-day) supply of specialty drugs even if obtained through a ninety-day (90-day) retail or mail order program.
- More than the quantities and doses allowed per prescription of select drugs unless the prescribing physician obtains preauthorization from BCBSM.
- More than twelve (12) doses of an impotence drug in a thirty (30) day period.
- Any drug determined to be experimental or investigational by BCBSM.
- Any covered drug entirely consumed at the time and place of the prescription.
- Anything other than a covered drug or service that is a pharmaceutical benefit.
- Administration of covered drugs; e.g., injections.
- Non-self-administered contraceptive drugs or devices.
- Diagnostic agents.
- Any drug or device prescribed for uses or in doses other than those specifically approved by the FDA. 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.
- Select chemotherapy specialty pharmaceuticals that are not preauthorized.
- Drugs that are not labeled FDA-approved, except for state-controlled drugs and insulin or such drugs that BCBSM designates as covered.
- Drugs newly approved by the FDA and not yet reviewed for coverage determination by BCBSM.

- Drugs not recommended and/or approved by BCBSM.
- Drugs that would be covered as a Medical benefit under a BCBSM medical certificate.
- Drugs or services obtained before the effective date of this contract or after this contract ends.
- Non-preferred co-branded drugs unless they are preauthorized by BCBSM.
- Costs for covered drugs or services submitted after the applicable time limit for filing a claim.
- Support garments or other non-medical items.
- Any contraceptive medications and devices, whether over-the-counter or FDA-approved or not, regardless of the reason they were prescribed or their intended use other than noted as a covered benefit or required to be covered under the Patient Protection and Affordable Care Act.
- Compound drugs that contain any bulk chemical powders that are not approved by BCBSM.
- Prescription drug services for the treatment of gender dysphoria that are considered by BCBSM to be cosmetic or prescription drug treatment that is experimental or investigational.
- Compound hormones.
- Refills of prescriptions for covered drugs that exceed BCBSM's limits; i.e., refills before seventy-five percent (75%) of the time period the prescription covers has elapsed; i.e., thirty-day (30-day) prescription can be refilled after the twenty-three (23) days.
- More refills than the prescription allows.
- Drugs that do not meet prior authorization requirements, cannot be split into short fill periods, or do not meet quantity limits or dose optimization criteria established by BCBSM.

I. Prescription Drug Manufacturer Coupon Assistance Program

The Fund implemented a Prescription Drug Manufacturer Coupon Assistance Program (Coupon Program) to assist with the lowering of prescription drug costs for you and your eligible family members. This Coupon Program is funded directly by the pharmaceutical company that manufacturers your prescription drug. These coupons provide you with lower out-of-pocket costs than what you would ordinarily pay under the Fund's current benefit structure. Health Plan Advocate (HPA) administers the Coupon Program.

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Participation in the Coupon Program is **mandatory** for all non-Medicare participants, Spouses and Eligible Dependents when:

- a prescription drug(s) that costs four hundred dollars ($400) or more is filled; **and**
- a manufacturer coupon is available.

HPA will contact you by mail and/or phone that a manufacturer coupon is available for your prescription drug. Also, your provider or pharmacist may advise you that one is available. If a manufacturer coupon becomes available after your prescription begins, HPA will provide you with notice of the required coupon.

In the event you choose not to use the coupon, ***Your coinsurance will increase to fifty percent (50%) of the cost of your prescription drug.***

Example: HPA contacts you that a manufacturer coupon is available for Prescription A. When you fill Prescription A, you do *not* bring the manufacturer coupon with you. Prescription A is a specialty drug and its cost is $2,000. Your prescription cost is $1,000.

HPA will notify you if your manufacturer coupon expires because you have met the monetary limit. If your coupon expires, you will no longer be required to participate in the Coupon Program for that prescription drug. Your cost sharing will revert to the traditional copayment schedule described above.

Note: Some manufacturer coupons may renew in a future calendar year. If so, HPA will notify you of your renewed manufacturer coupon and required participation in the Coupon Program.

Your out-of-pocket costs will change due to the Coupon Program. Your coinsurance will increase to fifty percent (50%) of the cost of your prescription drug. However, by using the manufacturer coupon, you will actually experience a reduction in the out-of-pocket amount you pay when you fill your prescription.

The Coupon Program does not cover the same amount of your out-of-pocket costs. The amount varies per prescription drug. Also, the manufacturer coupons do not apply to your out-of-pocket maximum.

If you have additional questions about the Coupon Program, contact the Fund Office.

SECTION 18: VISION BENEFITS

These benefits are for Active/Active Self-Pay Employees (and eligible family members), Early Retirees, non-Medicare Totally & Permanently Disabled Retirees, non-Medicare Surviving Spouses and non-Medicare Eligible Dependent(s).

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

Note: It is important that you use a VSP network provider to achieve the highest level of benefits under your VSP vision program. **Services received from a non-VSP provider are substantially less.** Contact VSP for applicable approved amounts.

Discounts may be available on additional prescription glasses and lens extras when obtained from a VSP network doctor.

Copayments	**VSP Network Provider**	**Non-VSP Provider**
Eye exam	No Copayment	No Copayment. (member responsible for difference between the approved amount and provider's charge)
Prescription glasses (lenses and/or frames)	No Copayment	No Copayment. (member responsible for difference between the approved amount and provider's charge)
Medically necessary contact lenses	No Copayment	No Copayment. (member responsible for difference between the approved amount and provider's charge)

Covered Services

Eye Exam

Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – **100%** of the approved amount	Reimbursement up to BCBSM's approved amount – currently **$45** (member responsible for any difference between the approved amount and the provider's charge)
	One eye exam per calendar year	

Lenses and Frames

Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also	Covered – **100%** of the approved amount	Reimbursement up to BCBSM's approved amount based on lens type (member responsible for any difference between the

covers prism, slab-off prism and special base curve lenses when medically necessary. **Progressive Lenses** – covered **only** when rendered by a VSP network provider	Covered – **100%** of the approved amount	approved amount and the provider's charge) **Not Covered**
	One pair of lenses, with or without frames, per calendar year	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	**$350** allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	Reimbursement up to BCBSM's approved amount - currently **$70** (member responsible for the difference between the approved amount and the provider's charge)
	One frame per calendar year	

Contact lenses

Medically necessary contact lenses **Note:** Requires prior authorization approval from VSP and must meet criteria of medically necessary.	Covered – **100%** of the approved amount	Reimbursement up to BCBSM's approved amount – currently **$210** (member responsible for the difference between the approved amount and the provider's charge)
	One pair of contact lenses each calendar year	
Elective contact lenses (prescribed, but do **not** meet criteria of medically necessary)	**$250** allowance that is applied towards contact lenses (member responsible for any cost exceeding the allowance)	Reimbursement up to BCBSM's approved amount – currently **$105** - which is applied toward contact lens exam, fitting and materials and the contact lenses (member responsible for the difference between the allowance and cost exceeding the allowance)
	Contact lenses are covered up to the allowance each calendar year	
Contact Lens Suitability Exam	**$60** copayment	**Not Covered**

(fitting and evaluation for non-medically necessary contact lenses) **Note:** Must use a VSP network provider**.**		

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

EXCLUSIONS AND LIMITATIONS

Note: The list below is not all inclusive and is subject to your certificates, riders and plan modifications.

- Additional charges for:
  - Lenses tinted darker than Rose tint #2 (such as sunglasses)
  - Oversize lenses (61 mm and larger)
  - Blended lenses
  - Photochromic lenses
  - Coating/laminating of a lens or lenses
  - Cosmetic lenses/processes
  - Two pair of glasses instead of bifocals
  - Antireflective lenses
- Medical-surgical treatment
- Medications administered during any service except an eye exam
- Services or eyewear ordered before coverage began
- Services not prescribed by an ophthalmologist or optometrist
- Special services, such as orthoptics, vision training, aniseikonic lenses and tonography
- Replacement of broken or lost lenses or frames
- Services available at no cost to you or for which no charge would be made in the absence of BCBSM coverage
- Charges for lenses or frames ordered while you were eligible for benefits but delivered more than sixty (60) days after coverage ends.
- Services available at no cost to you or for which no charge would be made in the absence of BCBSM coverage
- Charges for completing insurance forms
- Aphakic lenses when the patient lacks a natural lens
- Charges for experimental or poor-quality services
- Medically unnecessary services, glasses or contact lenses
- Experimental or investigational services
- BCBSM will not pay for the following when they have not been scientifically demonstrated to be safe and effective for treatment of the patient's condition –

- Services
- Procedures
- Treatments
- Devices
- Drugs
- Supplies
- Administrative costs related to experimental treatment or for research management.

SECTION 19: HEARING CARE BENEFITS

These benefits are for Active/Active Self-Pay Employees (and eligible family members), Early Retirees and non-Medicare Totally & Permanently Disabled Retirees, Surviving Spouses and Eligible Dependent(s).

Deductibles/Copayments	**Participating Provider**	**Non-participating Provider**
Deductibles	None	Not applicable
Copayments	None	Not applicable

A. Covered Services

You must receive the following services from a hearing care participating provider. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross Blue Shield plan does **not** contract with providers for hearing care services. For hearing care services outside of Michigan and without a participating network, BCBSM will pay their approved amount. **You may be responsible for charges that exceed BCBSM's approved amount.**

You must obtain a medical evaluation (sometimes called a medical clearance examination) performed by a physician-specialist before you receive your hearing aid(s). The medical evaluation is not a benefit under this hearing care program but is covered under your medical benefits for office visits. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation.

If you select a digitally controlled, programmable hearing device(s), you will be responsible for the charges that exceed the cost of a standard hearing aid(s).

Benefits	Participating Provider	Non-participating Provider
Audiometric exam – once every thirty-six (**36) m**onths	**100%** of the approved amount	Not covered
Hearing aid evaluation – once every thirty-six (**36)** months	**100%** of the approved amount	Not covered
Ordering and fitting of (standard) hearing aid(s) - monaural or binaural – once every thirty-six (**36)** months	**100%** of the approved amount	Not covered
Hearing aid conformity test – once every thirty-six (**36)** months	**100%** of the approved amount	Not covered

B. Participating Providers

In Michigan and outside of Michigan where the Blue Cross and Blue Shield plan contracts with providers for hearing care services, BCBSM pays the approved amount for hearing aids and related covered services only when obtained from participating providers.

C. Nonparticipating Providers

BCBSM does not pay for services performed by nonparticipating providers unless both the following occur:

- The services are performed outside of Michigan
- The local Blue Cross Blue Shield plan does not contract with providers for hearing care services

In such a case, BCBSM pays the approved amount for the hearing aid(s) and related covered services when obtained from nonparticipating providers. Your provider may participate with BCBSM on a per claim basis.

If the provider will not submit a claim for your covered services, you may submit a detailed receipt to BCBSM. BCBSM will pay you the approved amount.

D. Covered Services

BCBSM pays the approved amount for:

- An audiometric examination that:
  - Is performed by a participating physician-specialist, audiologist, or hearing aid dealer
  - Includes tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination
  - Includes a summary of findings
- A hearing aid evaluation test and a conformity test:
  - Prescribed by a physician
  - Performed by a participating physician-specialist, audiologist, or hearing aid dealer
- A monaural or binaural hearing aid that must be:
  - Designed to be worn in the ear, in the ear canal, behind the ear (including air conduction and bone conduction types) or on the body
  - Prescribed by a participating physician-specialist, audiologist, or hearing aid dealer based on the most recent audiometric examination and hearing aid evaluation test
  - The make and model prescribed by the participating physician-specialist, audiologist, or hearing aid dealer
  - Dispensed by a participating hearing aid dealer or participating licensed audiologist when services are obtained in Michigan
- BCBSM will pay for an audiometric examination, hearing aid evaluation, conformity tests and a hearing aid once every thirty-six (36) months. BCBSM will consider providing additional hearing care benefits within a thirty-six (36) month period if a physician-specialist sends BCBSM documentation of severe hearing loss that has occurred since the last examination. An example of severe hearing loss would be when a person wearing a hearing aid cannot distinguish normal speech twenty-five percent (25%) of the time.

E. Exclusions and Limitations

The list below may not be all inclusive and is subject to your certificate, riders and plan modification.

- Services performed by nonparticipating providers in Michigan and outside of Michigan where the Blue Cross and Blue Shield plan contracts with providers for hearing care services
- Medical or surgical treatment
- Drugs or other medications
- The trial and testing of different makes and models of hearing aids when the tests are not supported by the results of the most recent audiometric examination
- A medical evaluation by a physician-specialist to determine possible hearing loss (see medical benefits)
- Hearing aids ordered while you are a BCBSM member, but delivered more than sixty (60) days after coverage ends

- Charges for audiometric examinations, hearing aid evaluation test, conformity tests and hearing aids which are not necessary according to professionally accepted standards of practice, or which are not prescribed by the physician-specialist
- Charges for spare hearing aids
- Replacement of hearing aids that are lost or broken, unless you have not used this benefit for at least thirty-six (36) months
- Replacement parts for and repairs of hearing aids
- Any charges that exceed BCBSM's approved amount for covered hearing aids if you obtain digitally controlled programmable hearing devices
- Examinations related to medical-surgical procedures such as tonsillectomies or myringotomies
- Hearing aids that do not meet FDA and Federal Trade Commission requirements
- Two hearing aids ordered on different dates. These are not considered binaural hearing aids.

SECTION 20: BCBSM CLAIMS AND APPEALS PROCESS

The following claims and appeals information pertains to BCBSM medical, prescription drug, hearing and vision services.

A. Your Right to Request Review of an Adverse Benefit Determination (Appeal)

Most questions or concerns about decisions that have been made on claims or requests for benefits can be resolved through a phone call with a Customer Service Representative, using the phone number on the back of your BCBSM ID card. The appropriate phone number is also on the Explanation of Benefits (EOB) statement you receive for your medical, prescription drug, hearing and/or vision benefits or in the letter you may receive to notify you that your claim has not been approved. If you are unable to resolve your concern with a Customer Service Representative, ERISA's claims procedure rules protect you by providing you the opportunity to request a 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 the Plan. An adverse benefit determination also includes a rescission of coverage. You may request review of an adverse benefit determination on a **pre-service, urgent care** or a **post-service** claim.

"Pre-service claim" means a claim for a benefit where the 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 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, your claim will be treated as such. Absent a determination by your physician, a determination will be made whether the 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."

B. What You Should Also Know

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

Pre-service and post-service claims must be in writing. Urgent care claims or a request for an expedited review may be made orally or by facsimile or 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.

The following also applies to pre-service, urgent care and post-service claims:

- 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 appeal procedure.
- No fees or costs may be imposed as a condition for requesting an appeal.

    - Although there are set timeframes within which you must receive a final determination on all three types of claims, you have the right to allow additional time if you wish.
    - 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.
    - You may submit notarized statements, written comments, documents, records, and other information relating to your claim for benefits. This information will be considered even if it was not considered or submitted in the initial benefit determination.
    - 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.

- If your request for appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, including if a 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.
- 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.
- On review, you will be advised of the specific reason for an adverse benefit determination with reference to the specific plan provisions on which the determination is based.
- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse benefit determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion without charge upon request.
- If the adverse benefit determination is based on 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.

Note: For assistance, detailed information or for copies of forms, call the number on the back of your BCBSM ID card or visit BCBSM's website at **www.bcbsm.com/appealform/important information.**

APPEALS PROCESSES FOR MEDICAL, PRESCRIPTION DRUG, VISION AND HEARING SERVICES

C. Pre-Service Appeal Process

1. Internal Appeal Process:

If you have received an adverse benefit determination and you disagree with the decision, you or your authorized representative can ask for an appeal (i.e., review of your claim). Your request must be in writing. You have ***one hundred eighty (180) calendar days*** from the day you were notified of the denial or reduction of payment. You may either use BCBSM's Member Appeal Form or write a letter to submit your appeal. A Designated Authorized Representative Form must be provided if you have authorized an individual to represent you. Forms can be found on BCBSM's website. Your written request should include the following:

- The contract and group number from your BCBSM ID Card
- A daytime phone number for both you and/or your authorized representative if applicable

- The patient's name
- An explanation of why you disagree with the decision you received along with any additional information you choose to send

You will be notified of a final decision within thirty (30) calendar days of BCBSM's receipt of your appeal (or longer if you have authorized additional time). If you disagree with BCBSM's final determination, or if BCBSM fails to provide a final determination within thirty (30) calendar days of the date that BCBSM receives your original written appeal, you may be eligible for an external review by an Independent Review Organization (IRO).

Your request should be sent to:

Medical Services (includes Hearing)
Appeals Unit
Blue Cross Blue Shield of Michigan
600 Lafayette East – Mail Code #1620
Detroit, MI 48226-2998

Prescription Drugs
FAX: (866) 915-9187
Pharmacy Services
Blue Cross Blue Shield of Michigan
P.O. Box 312320
Detroit, MI 48231-2320

Medical Specialty Prescription Drugs
FAX: (866) 915-9187
Specialty Pharmacy Appeals
Blue Cross Blue Shield of Michigan
P.O. Box 312320
Detroit, MI 48231-2320

Vision Services
Phone: (800) 877-7195
VSP Appeals
P.O. Box 2350
Rancho Cordova, CA 95741

2. External Appeal Process

If your claim is denied, you may be eligible for an **external review** at no cost to you through an Independent Review Organization (IRO). BCBSM will provide you with instructions for requesting an external review, if applicable, in the letter you receive denying your claim.

If you choose to file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review process. You must request an external review within four (4) months of receipt of your BCBSM appeal denial.

Complete the BCBSM External Review Request Form. Return it to:

BCBSM External Review Requests
Blue Cross Blue Shield of Michigan
600 Lafayette East – Mail Code #1620
Detroit, MI 48226

BCBSM will randomly assign your request for an external review to a contracted IRO within five (5) days of receiving your request for external review.

The IRO will notify you whether your request is accepted for external review.

The IRO will determine if the appeal is based on medical judgment. If the appeal is not based on medical judgment, the original decision will be the final decision because non-medical appeals are not eligible for an external review. If the appeal is based on medical judgment, the IRO will review your appeal and make a decision whether to uphold or reverse the adverse decision. You will receive a written notification of the decision within forty-five (45) calendar days. The decision of the IRO will be binding on you, BCBSM and the Plan Administrator.

3. Civil Action

If you disagree with the final determination, or if the determination at each level is not issued within the applicable 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.

D. Urgent Care Appeal Process

1. Internal Appeal Process

Within ten (10) days of receipt of a denial for an urgent care service, you or your authorized representative may file a request for an **urgent care internal** appeal if you believe that your claim has been wrongfully denied, terminated or your coverage has been reduced for a health care service prior to your having received that health care service, or if you failed to receive a response in a timely manner to a request for a benefit or payment.

You may submit a request for an urgent internal review by telephone. The required physician's substantiation that your condition qualifies for an expedited appeal can also be submitted by telephone as follows:

Medical Services: Phone: (313) 225-0646

Pharmacy Services: Phone: **(**313) 225-0646

Vision Services: Phone: (800) 877-7195

If you need further assistance or have questions, you should call the number included in the notice you received denying approval of the service or call the customer service number on the back of your BCBSM ID card.

You must be provided a decision as soon as possible, taking into account the medical exigencies, but not later than ***seventy-two (72) hours*** after receipt of your request and your physician's substantiation of need has been received for review. All necessary information, including the decision on your request will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If the decision you receive is communicated orally, you or your authorized representative must be provided with written confirmation of the decision within two (2) business days.

2. External Appeal Process

If you do not agree with the decision you received, you or your representative may request an urgent **external** review. Your request must be submitted within ***ten (10) days*** of your receipt of the denial, termination or reduction in coverage for a health care service. You must also authorize the release of medical records that may be required to reach a decision during the external review. Your appeal and/or the form sent to you for filing an appeal, can be faxed or mailed to the address included in your letter denying your claim to:

Medical Services:
PHONE: (313) 225-0646
FAX: (877) 348-2210
MAIL: External Review
Blue Cross Blue Shield of Michigan
600 East Lafayette – Mail Code #1620
Detroit, MI 48226-2998

Pharmacy Services:
PHONE: (313) 225-0646
FAX: (877) 348-2210
MAIL: External Review
Blue Cross Blue Shield of Michigan
600 East Lafayette – Mail Code #1620
Detroit, MI 48226-2998

Vision Services:
PHONE: (877) 999-6642
FAX: (517) 284-8837

Website:
https://difs/state/mi.us/complaints/externalreview/aspx
MAIL: Dept. of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Your request will be randomly assigned to an Independent Review Organization (IRO) who will determine if your request qualifies for an expedited review. The IRO will decide within ***seventy-two (72) hours*** if it will uphold or reverse the decision and then notify you of its decision. Note that only appeals concerning medical issues are eligible for an external review.

3. Civil Action

If you disagree with the final determination, or if you fail to receive a final determination within the applicable time frame, or otherwise fail to receive a reply that complies with the appeal procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

E. Post Service Appeal Process

1. Internal Appeal Process

To initiate an internal appeal, you or your authorized representative must send a written statement explaining why you disagree with the determination. You must request a review no later than one hundred eighty (180) calendar days after you receive a decision on your claim for benefits. 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.

Mail your written request for review to:

Medical Services
Appeals Unit
Blue Cross Blue Shield of Michigan
600 Lafayette East – Mail Code #1620
Detroit, MI 48226-2998

Prescription Drugs
FAX: (866) -612-0627
Pharmacy Services
Blue Cross Blue Shield of Michigan
P.O. Box 312320

Detroit, MI 48231-2320

Medical Specialty Prescription Drugs
FAX: (866) 612-0627
Specialty Pharmacy Appeals
Blue Cross Blue Shield of Michigan
P.O. Box 312320
Detroit, MI 48231-2320

Vision Services
Phone: (800) 877-7195
VSP Appeals
P.O. Box 2350
Rancho Cordova, CA 95741

You should receive a response to your request for review in writing within sixty (60) days (unless you allow for additional time) of the date your original written appeal was received. If you agree with the response, this becomes a final determination and the review ends.

2. External Appeal Process

If your claim is denied, you may be eligible for an **external review** at no cost to you through an Independent Review Organization (IRO). BCBSM will provide you with instructions for requesting an external review, if applicable, in the letter you receive denying your claim.

If you choose to file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review process. You must request an external review within four (4) months of receipt of your denied appeal. Complete the BCBSM External Review Request Form. Return it to:

BCBSM External Review Requests
Blue Cross Blue Shield of Michigan
600 Lafayette East – Mail Code #1620
Detroit, MI 48226

BCBSM will randomly assign your request for an external review to a contracted IRO within five (5) days of receiving your request for external review.

The IRO will notify you whether your request is accepted for external review. If the IRO needs additional information, you will be contacted directly.

The IRO will determine if the appeal is based on medical judgment. If the appeal is not based on medical judgment, then the original decision will be the final decision because non-medical appeals

are not eligible for external review. If the appeal is based on medical judgment, the IRO will review your appeal and make a decision whether to uphold or reverse the adverse decision. The decision of the IRO will be binding on you and the Plan Administrator. If accepted, the IRO will provide you with its determination within forty-five (45) days of its receipt.

3. Civil Action

If you disagree with the final determination, or if the determination at each level is not issued within the applicable 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.

SECTION 21: MEDICARE PLUS BLUE GROUP PPO (MAPD)

Important Information:

As long as you maintain enrollment in the Laborers' Metropolitan Health Care Fund MAPD program, it is imperative that you do not enroll in another Medicare Advantage program. Enrollment in any other Medicare Advantage program will result in immediate termination of your Laborers' Metropolitan Health Care Fund MAPD program.

The Medicare Plus Blue Group PPO is a Medicare Advantage Prescription Drug (MAPD) program. The MAPD program is a fully insured benefit administered by BCBSM and offered by the Fund. This MAPD Section is not a Medicare document. This MAPD Section is a summary of your medical, prescription drug and hearing benefits. A complete list of services can be found in your **Evidence of Coverage booklet and Benefits Summary Chart** which is sent to you by BCBSM. The Evidence of Coverage booklet and Benefit Summary Chart are incorporated by reference as part of this Plan.

The medical, prescription drug and hearing benefits described below are provided through the MAPD Program. **Enrollment in both Parts A and B of Medicare is mandatory in order to be enrolled in the MAPD Program.**

A. Medical and Hearing Benefits

This benefits chart for medical, prescription drug and hearing care benefits is a part of your Evidence of Coverage (EOC) that you receive directly from BCBSM. If there is a conflict in the language, the Evidence of Coverage booklet and Benefits Summary Chart controls.

This chart lists the services Medicare Plus Blue Group PPO (MAPD) covers and what you may be required to pay out-of-pocket.

The prescription drug formulary (drug list) is BCBSM's **Comprehensive Enhanced Formulary.**

Benefits are listed alphabetically under the following categories: Inpatient Services, Outpatient Services, Preventive Services, and Additional Benefits. A listing of benefits not covered by the plan immediately follows the medical benefits.

The services listed in this chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in this Medical Benefits Chart are covered as in-network services only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from MAPD.
    - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the Medical Benefits Chart.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don't need approval in advance for out-of-network services, you or your doctor can ask BCBSM to make a coverage decision in advance.

This MAPD program consists of In-network and Out-of-network providers for medical benefits and Preferred and Standard pharmacies for prescription benefits as follows:

- Medical Benefits – In-network providers are contracted and participate in BCBSM's MAPD PPO program. Out-of-network providers are contracted with Medicare and participate with Medicare. Your medical benefits are the same whether you use a BCBSM MAPD PPO provider or a provider who accepts Medicare.
- Prescription Drug Benefits – MAPD pharmacies are either considered Preferred or Standard. Prescription Drug cost sharing is lower if you use a Preferred pharmacy.

Other important things to know about BCBSM coverage:

- Like all Medicare health plans, MAPD covers the same service that Original Medicare covers. If you want to know more about the coverage and costs of Original Medicare, information can be found in the Medicare & You Handbook. You can view the Handbook online at https://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- For all preventive services that are covered at no cost under Original Medicare, MAPD also covers the service at no cost to you. However, if you are treated or monitored for an existing

medical condition during a preventive service, your medical care is considered a separate service.

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services, either Medicare or the BCBSM's MAPD plan will cover those services.

Your services are covered in full provided you use a MAPD PPO provider or use a provider who accepts Medicare.

Type of maximum	In-network and Out-of-network
Annual deductible	There is no deductible
Part A and Part B combined benefit out-of-pocket maximum	There is no out-of-pocket cost sharing for medica benefits as outlined below

1. Services that are Covered for You

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
Home health agency care*	
Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: · Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) · Physical therapy, occupational therapy, and speech therapy · Medical and social services · Medical equipment and supplies Medical supplies ordered by physicians, such as durable medical equipment, are not covered under home health agency care. See Durable Medical Equipment for more information. * Home health agency care services may require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Services are covered up to 100% of the approved amount. Medical supplies ordered by physicians, such as durable medical equipment are not covered under home health agency care. See Durable Medical Equipment below. Please Note: Custodial care is not the same as home health agency care. For information, see Custodial Care in the exclusion list below.

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: · Drugs for symptom control and pain relief · Short-term respite care · Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than the MAPD Plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in the MAPD network: · If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services if applicable.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid by Original Medicare, not MAPD.

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
· If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services if applicable. For services that are covered by MAPD, but are not covered by Medicare Part A or B: MAPD will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. For drugs that may be covered by MAPD's Part D benefit: Drugs are never covered by both hospice and MAPD at the same time. For more information, please see What if you're in Medicare-certified hospice? in the Evidence of Coverage booklet you received from BCBSM. **Note:** If you need non-hospice care (i.e., care that is not related to your terminal prognosis), you should call the number on the back of your BCBSM ID card for assistance.	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: · Semi-private room (or a private room if medically necessary) · Meals including special diets · Regular nursing services	You have an unlimited number of medically necessary inpatient hospital days. Medicare approved clinical lab services and preventive services are covered at 100% of the approved amount. In-network and Out-of-network: Facility evaluation and management services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
· Costs of special care units (such as intensive care or coronary care units) · Drugs and medications · Lab tests · X-rays and other radiology services · Necessary surgical and medical supplies · Use of appliances, such as wheelchairs · Operating and recovery room costs · Physical, occupational, and speech language therapy · Inpatient substance abuse services · Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, BCBSM will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. · Transplant providers may be local or outside of the service area. If MAPD in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If MAPD provides transplant services at a location outside the pattern of care for transplants in your community, and you choose to obtain transplants at this distant location, BCBSM will arrange or pay for appropriate lodging and transportation costs for you and a companion. Coverage is up to $5000; travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant). Outside of the service area is defined as 100 miles or more, one-way to the facility, from your home address.	All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
· Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. · Physician services * Inpatient hospital care services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask at https://www.medicare.gov/sites/default/files/2018-09/ 11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048. You can all these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care*	
Covered services include mental health care services that require a hospital stay. There is a lifetime limit of 190 days for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in	MAPD covers 90 days for a benefit period. A benefit period starts the day you go into an inpatient psychiatric hospital. It ends when you go for 60 days in a row without hospital or skilled nursing care.

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
a psychiatric unit of a general hospital. * Inpatient mental health/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	If you go into an inpatient psychiatric hospital after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. In-network and Out-of-network: Facility evaluation and management services are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount.
Inpatient Stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, MAPD will not cover your inpatient stay. However, in some cases, MAPD will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: · Physician services · Diagnostic tests (such as lab tests) · X-ray, radium, and isotope therapy including technician materials and services · Surgical dressings · Splints, casts and other devices used to reduce fractures and dislocations · Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body	Medicare-approved clinical lab services are covered up to 100% of the approved amount. In-network and Out-of-network: Facility evaluation and management services are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
organ, including replacement or repairs of such devices · Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition · Physical therapy*, speech therapy*, and occupational therapy* * Physical, speech, and occupational therapy services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Skilled nursing facility (SNF) care* No prior hospital stay is required. Private duty nursing is not covered. Covered services include, but are not limited to: · Semiprivate room (or a private room if medically necessary) · Meals, including special diets · Skilled nursing services Physical therapy, occupational therapy, and speech therapy · Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) · Blood - including storage and administration.	MAPD covers up to 100 days for each benefit period. A benefit period begins the day you are admitted to a hospital or SNF as an inpatient and ends after you have not been an inpatient of a hospital (or received skilled care in a SNF) for 60 consecutive days. Once the benefit period ends, a new benefit period begins when you have an inpatient admission to a hospital or SNF. New benefit periods do not begin due to a change in diagnosis, condition, or calendar year. In-network and Out-of-network: Facility evaluation and management services are covered up to 100% of

Services that are covered for you	What you must pay when you get these services
Inpatient Services	
Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. · Medical and surgical supplies ordinarily provided by SNFs · Laboratory tests ordinarily provided by SNFs · X-rays and other radiology services ordinarily provided by SNFs · Use of appliances such as wheelchairs ordinarily provided by SNFs · Physician/Practitioner Services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts MAPD amounts for payment. · A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). · A SNF where your spouse is living at the time you leave the hospital. * Skilled nursing facility care may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	the approved amount. All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Ambulance services · Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. · Non-emergency transportation by ambulance* is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. · Covers transport of a hospice patient to their home before enrolling in a Medicare-certified hospice program. * In-network non-emergency services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Medicare-covered ambulance services are covered up to 100% of the approved amount.
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. MAPD also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. * Cardiac rehabilitation services may require prior	In-network and Out-of-network: Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Chiropractic Services* Covered services include manual manipulation of the spine to correct subluxation. **Your plan includes additional chiropractic services. See Additional Benefits section below for a description and cost sharing.** * Chiropractic services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Services are covered up to 100% of the approved amount.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. **MAPD covers Medicare-covered dental services only.** **Note:** See the Physician/Practitioner Services, including doctor's office visits benefit for examples of Medicare-covered dental services.	Original Medicare covers very limited medically necessary dental services. MAPD will cover those same medically necessary services. For more information, call the number on the back of your BCBSM ID Card.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Diabetes self-management training, diabetic services and supplies*	
For all people who have diabetes (insulin and non-insulin users). Covered services include: Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors · For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. · Diabetes self-management training is covered under certain conditions · For all people who have diabetes and use insulin, covered services: therapeutic continuous glucose monitors and supply allowance for the therapeutic continuous glucose monitor as covered by Original Medicare * Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization. To use an in-network supplier for diabetic supplies, contact J&B Medical Supply Company at 1-888-896-6233 from 8:00 a.m. to 5:00 p.m., Monday through Friday. TTY users call 711.	In-network and Out-of-network: Services are covered up to 100% of the approved amount for diabetes self-management training, diabetic services and supplies. You may be required to pay a pharmacy coinsurance for medical supplies obtained from a pharmacy.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
To use an in-network supplier for diabetic shoes and inserts, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5:00 p.m., Monday through Friday. TTY users call 711.	
Durable medical equipment (DME) and related supplies* Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. MAPD covers all medically necessary DME covered by Original Medicare. If the supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available at www.bcbsm.com/providersmedicare. **Note:** You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services. To use an in-network provider in Michigan, contact Northwood at 1-800-667-8496. 8:30 a.m. to 5:00 p.m. Monday through Friday. TTY users call 711. * Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You	In-network and Out-of-network: Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Emergency care Emergency care refers to services that are: · Furnished by a provider qualified to furnish emergency services, and · Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. **MAPD includes the foreign travel health care benefits. See Additional Benefits for a description and cost sharing.**	In-network and Out-of-network: Medicare-covered emergency room visits are covered up to 100% of the approved amount. For information on Observation Care, see Outpatient Hospital Services.
Worldwide Coverage Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. <u>Outside the U.S.:</u> You may be responsible for the difference between the approved amount and the provider's charge.	

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist or other qualified provider. Diagnostic hearing exam – 1 per year. **MAPD includes both the routine hearing exam and hearing aid benefits. See Additional Benefits for a description and cost sharing.**	In-network and Out-of-network: Diagnostic hearing office visits are covered up to 100% of the approved amount. Diagnostic testing services are covered up to 100% of the approved amount.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. MAPD Members receive coverage for these drugs. Covered drugs include: · Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services · Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan · Clotting factors you give yourself by injection if you have hemophilia · Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant · Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug · Antigens · Certain oral anti-cancer drugs and anti-nausea drugs · Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents	Benefits are covered up to 100% of the approved amount for drugs used in covered durable medical equipment (i.e., a nebulizer), certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs following a Medicare-covered transplant. In-network and Out-of-network: All other benefits are covered up to 100% of the approved amount. Retail and mail-order drugs are covered by your BCBSM Part D prescription drug plan and are subject to copayments as outlined under Pharmacy Benefits.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
(such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). · Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases · Covered Part B drugs that may be subject to step therapy include: anti-cancer agents and cancer-supportive therapy agents, anti-gout agents, anti-inflammatory agent, antirheumatic agents, antispasticity agents, bisphosphonates, blood products, gastrointestinal agents, immunosuppressive agents, knee injections, ophthalmic agents, respiratory agents Go to: https://www.bcbsm.com/content/dam/public/Providers/Documents/ma-ppo-bcna-medical-drugs- prior-authorization.pdf for a list of Part B Drugs that may be subject to Step Therapy. * Medicare Part B drugs may require prior authorization and/or step therapy; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. MAPD Members receive coverage for these services. Covered services include: · FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable · Substance use counseling · Individual and group therapy · Toxicology testing	In-network and Out-of-network: Opioid treatment program services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Outpatient diagnostic tests and therapeutic services and supplies*	
Covered services include, but are not limited to: · X-rays · Radiation (radium and isotope) therapy including technician materials and supplies · Surgical supplies, such as dressings · Splints, casts and other devices used to reduce fractures and dislocations · Laboratory tests · Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. · Other outpatient diagnostic tests including sleep studies High-tech radiology services (e.g., CAT scans, echocardiography, MRAs, MRIs, PET scans or nuclear medicine) rendered by plan providers require prior authorization. **Note**: For Medicare-covered diagnostic radiological services and Medicare-covered X-ray services, refer to Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers. * Outpatient diagnostic tests and therapeutic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Services are covered up to 100% of the approved amount for Medicare-approved diagnostic lab services rendered at a preferred Joint Venture Hospital Lab (JVHL) or Quest Diagnostics Lab. All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Outpatient hospital services* MAPD covers medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: · Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery · Laboratory and diagnostic tests billed by the hospital · Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it · X-rays and other radiology services billed by the hospital · Medical supplies such as splints and casts · Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You may receive other services while in observation or an outpatient hospital facility. The cost for those services can be found in this document. * Outpatient hospital services may require prior authorization; your provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Services are covered up to 100% of the approved amount. Medicare-covered emergency room visits are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Outpatient mental health care* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. * Outpatient mental/behavioral health services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Mental health services in an office are covered up to 100% of the approved amount. Mental health services rendered at a mental health facility are covered up to 100% of the approved amount.
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). * Outpatient rehabilitation services rendered by providers may require prior authorization; your provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	Original Medicare therapy limits do not apply to rehabilitation services provided. In-network and Out-of-network: Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Your plan includes the Removal of Medicare service caps for Outpatient rehabilitation services. See "Additional Benefits" for a description.	
Outpatient substance abuse services* Coverage under Medicare Part B is available for treatment services provided in the outpatient department of a hospital. A coverage example is a patient who has been discharged from an inpatient stay for the treatment of substance abuse or who requires additional treatment but does not require services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. * Outpatient mental/substance abuse services may require prior authorization; your provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Substance abuse treatment services in an office are covered up to 100% of the approved amount. Substance abuse treatment services rendered at a facility are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." * Outpatient surgery services, including services provided at hospital outpatient facilities and ambulatory surgical centers may require prior authorization; your provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Services are covered up to 100% of the approved amount.
Partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. * Partial hospitalization services may require prior authorization; your provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Physician/Practitioner services, including doctor's office visits **Covered services include:** · Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location · Consultation, diagnosis, and treatment by a specialist · Basic hearing and balance exams performed by your primary care provider or specialist, if your doctor orders it to see if you need medical treatment. · Certain telehealth services including consultation, diagnosis and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare · Additional telehealth services including primary care physician services and individual sessions for mental health specialty services. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. You can also use Blue Cross Online Visits to access telehealth services. Visit www.bcbsmonlinevisits.com for more information. · Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home · Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke · Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24	In-network and Out-of-network: Facility evaluation and management services are covered up to 100% of the approved amount. An annual routine physical exam is covered up to 100% of the approved amount. Office visits are covered up to 100% of the approved amount. Surgical services performed in an office are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
hours or soonest available appointment · Second opinion prior to surgery · Remote evaluation of pre-recorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment Consultation your doctor has with other physicians via telephone, Internet, or electronic health record assessment—if you are an established patient. · Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). · Total body skin examination performed by a trained health care professional, usually a dermatologist, to search for any unusual or suspicious lesions or conditions on the skin's surface, including hands and arms, legs and feet, torso, scalp, inside of the mouth and external genital area. Covered once in a lifetime. Note: Provider offices or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. If a biopsy or removal of a lesion or growth is performed during an office visit, these procedures are considered diagnostic you will be responsible for the Medicare-covered surgical service cost-share in addition to your office visit copayment. **Note:** Your plan includes an annual physical exam with no	

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
coinsurance, copayment, or deductible. See Additional Benefits for a description of coverage.	
Podiatry services* Covered services include: · Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). · Routine foot care for members with certain medical conditions affecting the lower limbs **Note:** For services other than office visits, refer to the following sections of this benefit chart for member cost-sharing: · Physician/Practitioner services, including doctor's office visits Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers · Outpatient diagnostic tests and therapeutic services and supplies * Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Podiatry services in an office are covered up to 100% of the approved amount. Some medically necessary foot care services other than office visits are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery. See "Vision Care" later in this section for more details. **Note**: You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Prosthetic and Orthotic (P&O) items and services. * Prosthetic devices and related supplies may require prior authorization; your provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	In-network and Out-of-network: Services are covered up to 100% of the approved amount.
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. * Pulmonary rehabilitation services may require prior authorization; your provider will arrange for this authorization, if needed. If treatment or service is denied,	In-network and Out-of-network: Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
you will receive a written explanation of the reason, your right to appeal the denial and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Services to treat kidney disease* Covered services include: · Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. · Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) · Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) · Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) · Home dialysis equipment and supplies Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the listed benefit, "Medicare Part B prescription drugs." * Dialysis services may require prior authorization; your plan provider will arrange for this authorization, if needed.	Kidney disease education services are covered up to 100% of the approved amount. In-network and Out-of-network: Dialysis services are covered up to 100% of the approved amount. Professional charges are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	In-network and Out-of-network: Services are covered up to 100% of the approved amount.
Urgently needed services Urgently needed services are provided to treat a non-	In-network and Out-of-

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Your plan includes the foreign travel health care benefit. See Additional Benefits for a description and cost sharing. **Worldwide Coverage** MAPD includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. **Outside the U.S.:** You may be responsible for the difference between the approved amount and the provider's charge.	network: Services are covered up to 100% of the approved amount.
Vision care Covered services include: · Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. · For people with diabetes, screening for diabetic retinopathy is covered once per year One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you	Routine eye exams and eyeglasses are not covered by this plan. Services are covered up to 100% of the approved amount for corrective lenses following cataract surgery. In-network and Out-of-network: Medical vision services in an office are covered up to 100% of the

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	approved amount. Diagnosis and treatment of diseases and conditions of the eye are covered up to 100% of the approved amount.

Services are covered for you	What you must pay when you get these services
Preventive Services	
Note: For preventive services that are covered at no cost under Original Medicare, MAPD also covers the same services at no cost to you.	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit cannot take place within 12 months of your "Welcome to Medicare" preventive visit. However, you are not required to have a "Welcome to Medicare" preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered once every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. If you have a medical condition or

Services are covered for you	What you must pay when you get these services
Preventive Services	
bone loss, or determine bone quality, including a physician's interpretation of the results.	further testing is required, the procedure and/or the subsequent testing is considered diagnostic.
Breast cancer screening (mammograms) Covered services include: · One baseline mammogram between the ages of 35 and 39 · One screening mammogram every 12 months for women age 40 and older · Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) MAPD covers one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you are eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease risk reduction preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: · For all women: Pap tests and pelvic exams are covered once every 24 months. **Note:** If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Services are covered for you	What you must pay when you get these services
Preventive Services	
Colorectal cancer screening For people 50 and older, the following are covered: · Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: · Guaiac-based fecal occult blood test (gFOBT) · Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, MAPD covers: · Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, MAPD covers: · Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If you have a medical condition, such as gastrointestinal symptoms, or further testing is required, the procedure and/or the subsequent testing is considered diagnostic.
Depression screening MAPD covers one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening MAPD covers this screening (includes fasting	There is no coinsurance, copayment,

Services are covered for you	What you must pay when you get these services
Preventive Services	
glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	or deductible for the Medicare-covered diabetes screening tests.
Glaucoma screening Glaucoma screening once per year for people who fall into at least one of the following high risk categories: · people with a family history of glaucoma · people with diabetes · African Americans who are age 50 and older · Hispanic Americans who are age 65 and older	There is no coinsurance, copayment, or deductible for Medicare-covered glaucoma screening for people at high risk.

Services are covered for you	What you must pay when you get these services
Preventive Services	
Health and Wellness education programs Supplemental programs designed to enrich the health and lifestyles of members. The plan covers the following supplemental education and wellness programs: · Telemonitoring Services · Members who are diagnosed with heart failure may be targeted for the remote	There is no coinsurance, copayment, or deductible for health and wellness education programs.

monitoring intervention. · Members in the program will be sent a symptom appropriate monitor and provided with the support needed to operate it. · Tobacco Cessation Coaching is a 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program. Tivity Health™ SilverSneakers® fitness program	
Hepatitis C screening For people who are at high risk for Hepatitis C infection, including persons with a current or history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992, we cover: · One screening exam · Additional screenings every 12 months for persons who have continued illicit injection drug use since the prior negative screening test For all others born between 1945 and 1965, one screening exam.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive Hepatitis C screening.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: · One screening exam every 12	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.

months For women who are pregnant, MAPD covers: Up to three screening exams during a pregnancy	

Services are covered for you	What you must pay when you get these services
Preventive Services	

Immunizations
 	
Covered Medicare Part B services include:
 	
· Pneumonia vaccine
  · An initial pneumococcal vaccine to Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
  · A different, second pneumococcal vaccine 1 year after the first vaccine was administered
· Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary
· Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
· Other vaccines if you are at risk and they meet Medicare Part B coverage rules
 	
MAPD also covers some vaccines under Part D prescription drug benefits.
 	
Other Medicare-covered vaccines (such as shingles vaccine or tetanus booster) may be covered by your Medicare Part D prescription drug coverage. What you pay for vaccinations covered by Part D will depend on where you receive the vaccine. If your vaccine is administered during an office visit, you may have an additional charge.
	There is no coinsurance, copayment, or deductible for pneumonia, influenza and Hepatitis B vaccines.
	
	Flu and pneumonia shots are also available at retail network pharmacies.

Services are covered for you	What you must pay when you get these services
Preventive Services	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. MAPD covers 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare, and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew the order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services are covered for you	What you must pay when you get these services
Preventive Services	
in a primary care setting where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: · Digital rectal exam Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam.
Screening and counseling to reduce alcohol misuse MAPD covers one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. Eligible enrollees are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Services are covered for you	What you must pay when you get these services
Preventive Services	
written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs MAPD covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. MAPD also covers up to 2 individual 20 to 30 **minute, face-to-face high-intensity behavioral counseling sessions each year for sexually** active adults at increased risk for STIs. MAPD will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.

Services are covered for you	What you must pay when you get these services
Preventive Services	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: MAPD covers two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: MAPD covers cessation counseling services. MAPD covers two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. Tobacco Cessation Coaching is a 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefit.
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

Services are covered for you	What you must pay when you get these services
Preventive Services	
referrals for other care if needed. **Important:** MAPD covers the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	

What services are covered for you	What you must pay when you get these services
Additional Benefits	
Acupuncture for chronic low back pain Covered services include: Up to twelve (12) visits in ninety (90) days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting twelve (12) weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease • Not associated with surgery and • Not associated with pregnancy An additional eight (8) sessions will be covered for those patients demonstrating an improvement. No more than twenty (20) acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	**In-network and Out-of-network:** Acupuncture for chronic low back pain services in an office setting is covered up to 100% of the approved amount. Acupuncture for chronic low back pain services other than office visits are covered up to 100% of the approved amount.

What services are covered for you	What you must pay when you get these services
Additional Benefits	
Annual physical exam Covered services include: One yearly routine physical exam (an annual preventive medical exam that is more comprehensive than an annual wellness visit) · An examination performed by a primary care physician or other provider that collects health information. Services include: · An age and gender appropriate physical exam, including vital signs and measurements. · Guidance, counseling and risk factor reduction interventions. · Administration or ordering of immunizations, lab tests or diagnostic procedures.	In-network and Out-of-network: Services are covered up to 100% of the approved amount. **Note**: If a biopsy or removal of a lesion or growth is performed during an office visit, these procedures are considered diagnostic.
Chiropractic services Covered services include: · Evaluation and management services · Spine X-rays and chiropractic radiology services · Chiropractic physical therapy visits	In-network and Out-of-network: Spine X-rays, other chiropractic radiological, chiropractic physical therapy services, and evaluation and management services are covered up to 100% of the approved amount.
Foreign travel health care – not restricted to emergency/urgent care MAPD provides coverage outside the United States for medical care that is not urgent or an emergency.	Your cost-share amount, if applicable, is the same as if services are rendered in the United States, if applicable.

What services are covered for you	What you must pay when you get these services
Additional Benefits	
Hearing aids A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is covered as an office visit when furnished by a physician, audiologist, or other qualified provider. The following tests are covered under the hearing aids benefit: · A hearing aid evaluation test to determine what type of hearing aid should be prescribed · A test to evaluate the performance of a hearing aid You are responsible for the difference between the plan's benefit and the cost of the hearing aid(s).	In-network and Out-of-network: Standard (analog or basic digital) hearing aids are covered up to $2,500 every 36 months.
Hearing services – routine exam The following test is covered as an office visit under the hearing services benefit when furnished by a physician, audiologist or other qualified provider: An annual routine exam to measure hearing ability	In-network and Out-of-network: Services are covered up to 100% of the approved amount.
Home infusion therapy Home infusion therapy is 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. Coverage for additional home infusion therapy service components are provided based on the member's condition. The additional MAPD home infusion therapy benefit provides coverage for the in-home administration of	In-network and Out-of-network: Services are covered up to 100% of the approved amount.

What services are covered for you	What you must pay when you get these services
Additional Benefits	

infusion therapy services when the Original Medicare coverage criteria are not met.
Coverage is available when the infusion therapy is:
 	
· Prescribed by a physician to:
  · Manage a chronic condition
  · Treat a condition that requires acute care if it can be managed safely at home
· Certified by the physician as medically necessary for the treatment of the condition
· Appropriate for use in the patient's home
· Medical IV therapy, injectable therapy or total parenteral nutrition therapy
 	
Components of care available regardless of whether the patient is confined to the home:
 	
· Nursing visits
· Durable medical equipment, medical supplies and solutions
· Catheter care
· Injectable therapy
· Drugs	

Non-medically necessary sterilization Sterilization is defined as the process of rendering barren. This is accomplished by surgical removal of testes or ovaries or inactivation by irradiation or by tying off or removing a portion of reproductive ducts (ductus deferens or uterine tubes).	In-network and Out-of-network: Services are covered up to 100% of the approved amount.
Removal of Medicare Caps for outpatient rehabilitation services The Medicare Part B outpatient rehabilitation therapy limits (occupational therapy, physical therapy, and speech-language therapy) do not apply.	In-network and Out-of-network: Medicare Part B limits do not apply to Outpatient Rehabilitation Services.

What services are covered for you	What you must pay when you get these services
Additional Benefits	
Tivity Health™ SilverSneakers® The SilverSneakers benefit doesn't include gym or health club memberships other than for those facilities that participate in the SilverSneakers fitness program. Benefits include: Fitness program membership at any participating location across the country · Customized SilverSneakers classes and seminars · A trained Senior Advisor℠ at the fitness center to show you around and help get you started · Conditioning classes, exercise equipment, pool, sauna and other available amenities SilverSneakers Steps℠ in-home fitness program for members without convenient access to a SilverSneakers facility	In-network and Out-of-network: Services are covered at 100%. The SilverSneakers Fitness Program is a specialized program designed for seniors. SilverSneakers provides access to exercise equipment, classes and fun social activities at thousands of locations nationwide.
Travel and lodging for covered transplants and clinical trials · The benefit period begins five days prior to the initial transplant and extends through the patient's transplant episode of care. The transplant surgery must be performed at a Medicare-approved transplant facility. · Travel and lodging benefits are also payable during covered clinical trials and begin with the first service date of the clinical trials and end 180 days after that date. · Coverage includes expenses for the patient and one other person eligible to accompany the patient and two persons if the patient is a child under age 18 or if the transplant involves a living donor. · Benefits are payable up to a combined maximum of $150 per day for the covered duration. The maximum amount payable for travel and lodging	In-network and Out-of-network: Services are covered up to 100% of the approved amount.

What services are covered for you	What you must pay when you get these services
Additional Benefits	
services related to the initial solid organ transplant is $10,000. The maximum amount payable for services related to an approved clinical trial or bone marrow transplant is $5,000.	

Note: The MAPD service area includes the entire United States and its territories. You have coverage for health care services regardless of the provider's network affiliation. It also covers emergency and urgent care services worldwide.

2. What services are not covered by the plan?

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by MAPD. If a service is "excluded," it means that MAPD doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. MAPD does not pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: BCBSM will pay if a service in the chart below is found upon appeal to be a medical service that should have paid for or covered because of your specific situation.

Exclusions or limitations on services are described in the Medical Benefits Chart or in the chart below.

Note: Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and MAPD will not pay for them.

Services not covered by Original Medicare	Services not covered by MAPD under any condition	Services covered by MAPD only under specific conditions
Acupuncture		√

Services not covered by Original Medicare	Services not covered by MAPD under any condition	Services covered by MAPD only under specific conditions
Care provided in conjunction with an ambulance call when no transport is provided. Ambulance service is a transport benefit, and it is only payable when you're transported to a hospital. If an ambulance is called and you receive care, but decide not to be transported to a hospital, MAPD does not cover those services. **Note:** See Ambulance Services section of the Medical Benefits Chart.		√
Cosmetic surgery or procedures		√ · Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. · Covered for all stages of reconstruction for a breast after a mastectomy as well as for the unaffected breast in order to produce a symmetrical appearance.
Covered prescription drugs beyond 90-day supply limit including early refill requests .	√	

Services not covered by Original Medicare	Services not covered by MAPD under any condition	Services covered by MAPD only under specific conditions
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	√ **Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.*	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		√ May be covered by Original Medicare under a Medicare-approved clinical research study or by the MAPD plan.
Fees charged for care by your immediate relatives or members of your household.	√	
Full-time nursing care in your home.	√	
Home-delivered meals	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	√	
Naturopath services (uses natural or alternative treatments).	√	
Non-routine dental care.		√

Services not covered by Original Medicare	Services not covered by MAPD under any condition	Services covered by MAPD only under specific conditions
		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes		√ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	√	
Phase III cardiac rehabilitation programs are considered maintenance programs, do not require physician supervision and monitoring, and are not considered medically necessary.	√	
Prescriptions written by prescribers who are subject to the plan's Prescription Prescriber Block policy .	√	
Private duty nurses	√	
Private room in a hospital.		√ Covered only when medically necessary.
Radial keratotomy (RK) and LASIK surgery.	√	
Reversal of sterilization procedures, non-prescription contraceptive supplies, including	√	

Services not covered by Original Medicare	Services not covered by MAPD under any condition	Services covered by MAPD only under specific conditions
Intrauterine Devices (IUDs), and/or any contraceptive method not payable under your Part D benefit.		
Routine chiropractic care		√ Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	√	
Routine eye examinations, eyeglasses and other low vision aids.		√ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		√ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		√
Services considered not reasonable and necessary, according to the standards of Original Medicare	√	
Services from providers who appear on the CMS Preclusion List.	√	
Supportive devices for the feet		√ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Original Medicare	Services not covered by MAPD under any condition	Services covered by MAPD only under specific conditions
Temporomandibular Joint Syndrome (TMJ)	√	
Vacation supplies of Medicare Part D drugs	√	

B. Prescription Drug Benefits

IMPORTANT PRESCRIPTION DRUG INFORMATION

Prescription drug coverage under this MAPD benefit plan satisfies the requirement for Part D prescription drug benefits under Medicare. It is imperative that you do not enroll in a separate Medicare Part D Prescription Drug Program. If you do enroll in any other Medicare Part D prescription drug plan, your MAPD coverage through this Fund will be immediately terminated.

BCBSM Network:
BCBSM has a network of Preferred and Standard pharmacies. You must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Note that copayments are lower for prescription drugs if you use a Preferred pharmacy as outlined below. You can access BCBSM's pharmacy directory at ww.bcbsm.com/pharmaciesmedicare. You can also call the number on the back of your BCBSM Drug ID card for assistance or to request a copy of BCBSM's Pharmacy Directory or Pharmacy Locator if you live outside of Michigan.

BCBSM Formulary:
You can see the complete plan formulary (drug list) for Part D prescription drugs and any applicable restrictions by accessing BCBSM's website at ww.bcbsm.com/formularymedicare.

For detailed information about your prescription drug coverage, reference the **Evidence of Coverage (EOC)** booklet and the Benefits Summary Chart you received from BCBSM or sign into BCBSM's Member Secured Services at www.bcbsm.com.

Note: This prescription drug plan includes prior authorization, step therapy and quantity limit restrictions for certain drugs.

Benefits, copayments and/or coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Covered Services and Copayments	Up to a 31-Day Supply	Preferred Retail and Preferred Mail-order Pharmacies	Standard Retail and Standard Mail-order Pharmacies
Tier 1	Preferred Generic Drugs	$10	$20
Tier 2	Generic Drugs	$10	$20
Tier 3	Preferred Brand Name Drug	$40	$50
Tier 4	Non-preferred Drugs	$60	$70
Tier 5	Specialty Drugs	$60	$70

Covered Services and Copayments	Up to a 90-Day Supply	Preferred Retail and Preferred Mail-order Pharmacies	Standard Retail and Standard Mail-order Pharmacies
Tier 1	Preferred Generic Drugs	$20	$40
Tier 2	Generic Drugs	$20	$40
Tier 3	Preferred Brand Name Drugs	$80	$100
Tier 4	Non-preferred Drugs	$120	$140
Tier 5	Specialty Drugs	90-Day Not Available	90-Day Not Available

Note: If your covered drug costs less than the copayment amount listed above, you will pay the lower price for the drug. In other words, you pay either the full price of the drug or the copayment amount, whichever is less.

For assistance with claims, billing, or general questions, please contact MAPD Customer Service. Customer Service also has free language interpreter services available for non-English speakers.

Important BCBSM Contact Information:

- BCBSM Customer Service (866) 684-8216
- TTY 711 (Dial for assistance)
- FAX (866) 624-1090
- Address Blue Cross Blue Shield of Michigan
  Customer Service Inquiry Dept.
  Mail Code X521
  600 E. Lafayette Blvd.
  Detroit, MI 48226-2998
- Website www.bcbsm.com/medicare

Miscellaneous Information

- You may get your drugs at network retail pharmacies or mail order pharmacies.
- You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at a BCBSM in-network pharmacy.
- You must continue to pay your Medicare Part B premium.
- Your Part D formulary is the Comprehensive Enhanced Formulary
- **Phase 1 - Deductible:** There is no deductible.
- **Phase 2 - Initial Coverage Stage:** You pay the copayments listed above until your out-of-pocket costs reach $6,350 (this amount can change each calendar year). See "Chapter 4: What you pay for your Part D prescription drugs" of your Evidence of Coverage for an explanation about how Medicare counts out-of-pocket costs.
- **Phase 3 - Coverage Gap:** This plan does not have a gap in coverage.
- **Phase 4 – Catastrophic Coverage:** If you reach this stage in a calendar year, most of the cost for prescriptions are covered by this Part D plan for the rest of the year.

SECTION 22: MEDICARE PLUS BLUE GROUP PPO (MAPD) ENROLLEES CLAIMS AND APPEAL PROCESS FOR MEDICAL AND PHARMACY BENEFITS

A. General Information

If your medical claim or prescription benefit is denied by BCBSM, you should first call the BCBSM appropriate number listed below. Most issues can be resolved through a phone call.

An appeal is a formal way of asking BCBSM to review and change a coverage decision BCBSM has made. If you decide to file an appeal, you should reference **"Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)"** of your Evidence of Coverage booklet for a detailed description of steps to take.

Below is a summary of the appeal process that can be found in the Evidence of Coverage (EOC) booklet. **If there is a conflict between the Evidence of Coverage and this section of the SPD, the EOC will control.**

To contact Medicare Plus Blue Group PPO (MAPD) customer service for a **Medical Appeal**:

- BCBSM Customer Service (**866) 684-8216**
- TTY 711 (Dial for assistance)
- FAX (877) 348-2251
- Write Blue Cross Blue Shield of Michigan
  Grievances and Appeals Department

P.O. Box 2627
Detroit, MI 48231-2627

- Website www.bcbsm.com/medicare

To contact Medicare Plus Blue Group PPO (MAPD) customer service for a **Part D Prescription Drug Appea**l:

- BCBSM Customer Service (**866) 684-8216**
- TTY 711 (Dial for assistance)
- FAX (866) 601-4428
- Write Blue Cross Blue Shield of Michigan
  Pharmacy Help Desk
  P.O. Box 807
  Southfield, MI 48307
  - Website www.bcbsm.com/complaintsmedicare

For any other Medicare problems or complaints, please review Chapter 9 of your Evidence of Coverage booklet.

You can contact Medicare directly for additional information:

- Medicare 800-MEDICARE (800) 633-4227
- TTY (877)486-2048
- Website www.medicare.gov

B. Appeal Process

You can appeal a coverage decision, that is when BCBSM decides what is covered for you and how much will be paid. In some instances, a service or drug is not covered or no longer covered by Medicare. There is a required two level appeal process. If you need a quick response, you may request a "fast appeal". For more details see page 135 of your EOC.

1. Level 1 Appeal Procedure

If you are not satisfied with BCBSM's initial coverage decision, you can appeal. BCBSM will review the decision and the procedures used to make that decision. Your appeal will be handled by different reviewers than those who made the first (unfavorable) decision. If you receive a favorable decision, you will receive coverage. BCBSM will make the appropriate changes. If your appeal is denied, you have a right to a Level 2 Appeal.

2. Level 2 Appeal Procedure

If BCBSM denies your Level 1 Appeal (in part or completely), your case will automatically be sent by BCBSM to the Level 2 Appeal process. This appeal is completed by an Independent Review Organization (IRO). If you are not satisfied with the Level 2 decision, you may be able to continue through additional levels of appeal.

See below for more information about the Appeal Process. For very detailed instructions, please consult your Evidence of Coverage Booklet. If there is a conflict between this SPD and the EOC Booklet, the EOC Booklet controls.

3. Request Assistance

You can receive assistance with your appeal by:

- Calling Medicare Plus Blue Group PPO (MAPD) Customer Service at (866) 684-8216

- Contacting the Michigan Medicare/Medicaid Assistance Program
  MMAP, Inc.
  6105 W. St. Joe Highway
  Suite 204
  Lansing, MI 48917
  (517) 866-1242 or (800) 803-7174
  www.mmapinc.org

- Requesting your doctor to make an appeal for you.

  Medical - Your doctor can make a Level 1 medical appeal on your behalf. If the appeal is denied it will automatically be forwarded to Level 2. However, your doctor must be formally appointed as your representative to request a Level 2 appeal.

  Pharmacy – Your doctor or other prescriber can make a Level 1 or Level 2 appeal on your behalf. If your claim is denied and you want to appeal further, your doctor or other prescriber must be formally appointed as your representative.

- Requesting an authorized representative act on your behalf.
  This person must have legal authority to represent you or you may complete the Appointment of Representative Form which is available on Medicare's website and also on BCBSM's website.

C. Level 1 Appeal (Standard) Process

Your Level 1 Appeal (also called a Standard Appeal) must be in writing. You must file your appeal within sixty (60) calendar days from the date on the written notice of the denial of the

coverage decision. If you miss the deadline, you *may* be granted additional time depending on your situation. Contact Customer Service if you need additional time.

You may request the information that was used by BCBSM in making the determination. You may also provide additional information to support your appeal. BCBSM may request additional information from your doctor. All information as well as proper procedures will be reviewed for your appeal.

BCBSM must respond to your medical coverage or service appeal within thirty (30) calendar days after your appeal is received and within seven (7) calendar days if it is a Medicare Bart B prescription drug appeal. BCBSM will respond sooner if your health condition requires it.

If extra time is needed to make a determination or you request more time, BCBSM will contact you in writing, but the process will not exceed fourteen (14) calendar days, for a medical item or service. BCBSM is not permitted to take additional time when determining Medicare Part B prescription drug appeals.

If BCBSM approves your appeal, in whole or in part, your coverage will be provided within thirty (30) calendar days for medical appeals or within seven (7) calendar days for Medicare Part B prescription drug appeals.

If your appeal is denied, in whole or in part, it will automatically be sent to the Independent Review Organization for a Level 2 Appeal.

D. Level 2 Appeal Process

1. Standard Level 2 Appeal

The Level 2 Appeal Process is conducted by the IRO which is an independent organization hired by Medicare. Your appeal information, called a "case file", will be sent to the IRO. You may request a copy of your case file. You may also provide additional information to the IRO in support of your appeal. Note: You cannot request a Fast Level 2 Appeal if your initial appeal was a standard appeal.

The IRO will review your initial appeal and any additional information that you submit in support of your appeal. If the IRO determines more information is necessary to make a **medical decision**, it may have up to fourteen (14) more calendar days to review your appeal and make a determination. If our appeal is for a Medicare Part B prescription drug, the IRO *cannot* take additional time to make a decision.

The IRO must provide a response within thirty (30) calendar days of receipt of your medical appeal. If your request is for a Medicare Part B prescription drug, the IRO will give you an answer

within seven (7) calendar days of when it receives your appeal. The IRO is required to provide a written response and the explanations behind the response.

2. IRO Response

Upon receipt of a favorable response, to all or part of your appeal, medical coverage will be provided within seventy-two (72) hours and medical service within fourteen (14) calendar days. If the IRO says yes to your Part B prescription drug appeal, the Plan will authorize or provide the Part B prescription drug within seventy-two (72) hours of receipt of the IRO's response.

If the IRO denies part or all of your appeal, you will not receive the requested coverage or service. You have a right to a Level 3 Appeal, provided the dollar value of the medical coverage you are requesting meets a certain minimum. If the minimum is not met, the Level 2 Appeal is final and binding. If the dollar value of your claim meets the required minimum, as provided in your written denial from the IRO, you may proceed with a Level 3 Appeal. *The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator.*

E. Fast Appeal Level 1 Process

To request a fast appeal, you or your authorized representative may make a request in writing or by calling Medicare Plus Blue Group PPO (MAPD) Customer Service. See the contact information above in this Section A. - General Information.

You will receive an answer within seventy-two (72) hours of your request for a medical item or service. If your health requires a faster response, BCBSM will provide an answer sooner. If extra time is needed to make a determination, BCBSM will contact you in writing, but it will not exceed fourteen (14) calendar days.

For a Medicare Part B prescription drug, you will be provided an answer within twenty-four (24) hours.

If BCBSM does not provide an answer within seventy-two (72) hours (or the extension), your request will automatically be sent to a Level 2 – Independent Review Organization.

If BCBSM reverses the decision (approves your appeal), your coverage must be provided within seventy-two (72) hours after your appeal is received.

If your appeal is denied, BCBSM will automatically send your appeal to the IRO for a Level 2 Appeal.

F. Fast Level 2 Appeal Process

1. Fast Level 2 Appeal

You will receive an expedited Level 2 review by an Independent Review Organization (IRO) which is hired by Medicare, if your initial appeal was a Fast Appeal. The IRO will provide a written response **within seventy-two (72) hours** of receipt of your appeal.

The IRO will review all of the information related to your appeal. You may request a copy of your case file and you may also provide additional supporting documents.

If the IRO determines more information is necessary to make a **medical decision**, it may have up to fourteen (14) more calendar days to review your appeal and make a determination. If our appeal is for a Medicare Part B prescription drug the IRO ***cannot*** take additional time to make a decision.

2. IRO Response

Upon receipt of a favorable response, to all or part of your appeal, medical coverage or service will be provided within seventy-two (72) hours of the IRO's response. If the IRO says yes to your Medicare Part B prescription drug appeal, the Plan will authorize or provide the Part B prescription drug within twenty-four (24) hours of receipt of the IRO's response.

If the IRO denies part or all of your appeal, you will not receive the requested coverage or service. You have a right to a Level 3 Appeal, provided the dollar value of the medical coverage you are requesting meets a certain minimum. If the minimum is not met, the Level 2 Appeal is final and binding.

G. Level 3 Appeal and Beyond for Medical Service

1. Level 3 Appeal Process

If your claim exceeds a certain minimum dollar value and your Level 1 and Level 2 Appeals have been denied, you may pursue a Level 3 Appeal, which is handled by an Administrative Law Judge (ALJ) or an attorney adjudicator.

If a Level 3 decision is *favorable* to you, BCBSM has the right to appeal the decision. If BCBSM does *not* appeal the decision, then you will be provided with the service within sixty (60) calendar days after receiving the ALJ's or attorney adjudicator's decision.

However, if BCBSM decides to appeal, BCBSM will notify you with a copy of the Level 4 Appeal request and any accompanying documents. Until the dispute is resolved, BCBSM may not provide the service in question.

If your Level 3 Appeal is denied, you may accept this decision and the appeals process is concluded. However, if you do not agree with the decision, you can continue to the Level 4 Appeal process, as described in your Level 3 denial letter.

2. Level 4 Appeal Process

If your Level 3 Appeal was denied, you may pursue a Level 4 Appeal with the Medicare Appeals Council (Council).

If the Council approves your Level 4 request or if the Council denies BCBSM's request to review a favorable Level 3 Appeal decision, the appeal process could go to a Level 5 appeal. If BCBSM appeals the Council's decision, you will receive a written notification. If BCBSM does not appeal the decision, BCBSM will authorize or provide services within sixty (60) calendar days of receiving the Council's decision.

If the Council denies your Level 4 request, you can accept the decision and the appeal process is over. However, if you are not satisfied with the Council's decision, you may be able to proceed to a Level 5 Appeal. The Council will provide you with information to determine if you are eligible for Level 5 Appeal.

3. Level 5 Appeal Process

At this level, a judge at the Federal District Court will review your appeal. This is the final step of the appeal process. If you are not satisfied with this outcome, you cannot appeal.

H. Level 3 Appeal and Beyond for Part D Drugs

1. Level 3 Appeal Process

If the value of the drug you have appealed meets a certain dollar amount and your Level 1 and Level 2 Appeals have been denied, you may pursue a Level 3 Appeal, which is handled by an Administrative Law Judge (ALJ) or an attorney adjudicator. If the value doesn't satisfy the dollar requirement, then you cannot appeal any further.

If you submit a Level 3 Appeal and the decision is *favorable* to you, then the drug coverage will be authorized or provided within seventy-two (72) hours (twenty-four (24) hours for expedited appeals) or BCBSM will pay for the drug coverage no later than thirty (30) calendar days after receiving the ALJ's or attorney adjudicator's decision.

If your Level 3 Appeal request is denied, you may accept this decision and the appeals process is concluded. However, if you do not agree with the decision, you can consider filing a Level 4 Appeal. Your written notification from the ALJ or attorney adjudicator will provide details about the Level 4 Appeal process.

2. Level 4 Appeal Process

You may pursue a Level 4 Appeal with the Medicare Appeals Council (Council) if you received a denial at Level 3.

If the Council approves your appeal, then the drug coverage will be authorized or provided within seventy-two (72) hours (twenty-four (24) hours for expedited appeals) or BCBSM will make a payment no later than thirty (30) calendar days after receiving the ALJ's or attorney adjudicator's decision.

If the Council denies your Level 4 request, you can accept the decision and the appeal process is over. However, if you do not accept the Council's decision, you may be able to proceed to a Level 5 Appeal. The Council will provide you with information to determine if you are eligible for Level 5 Appeal.

3. Level 5 Appeal Process

At this level, a judge at the Federal District Court will review your appeal. This is the final step of the appeal process. If you are not satisfied with this outcome, you cannot appeal.

I. Other Appeal Requests

1. Medical Reimbursement Request

If you ask BCBSM to reimburse you for medical care that you received, it is treated like a medical coverage claim. If the reimbursement request is approved, you will receive the payment within sixty (60) calendar days after receipt of the request or the payment will be sent directly to the provider.

If the reimbursement request is denied, you may appeal using the Standard Level 1 Appeal above. The request may be disallowed because the medical care is not covered or because you did not follow all the rules. So, you may make a written appeal and BCBSM will respond within sixty (60) calendar days of receipt of your appeal. Note: The Fast Appeal Process is not available if you have already paid for the claim.

If the appeal is denied it will go to an IRO for the Level 2 Appeal. If the IRO rules in favor of the appeal, a payment will be made to you or your provider within thirty (30) calendar days. If the IRO denies your reimbursement request, you may proceed to the Level 3 Appeal (and beyond if necessary). If any of the appeal levels determine you are entitled to reimbursement, BCBSM must make a payment to you or your provider within sixty (60) calendar days.

2. Medicare Part D Prescription Drug Coverage or Reimbursement

Coverage
If you request coverage for a Part D Prescription Drug that is not on the list of covered drugs formulary, ask to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier, or request any other exceptions to the current rules, and we deny that request, you can appeal the decision. See Chapter 9, Section 6 of your Evidence of Coverage Booklet for more detailed information and a list of exception examples frequently requested.

Initial Request
The initial request (claim) can be made by phone, fax or in writing. It can be done by you, your authorized representative, your doctor, or other prescriber. You must submit a supporting statement that is, an explanation by your doctor or prescriber which explains the medical reasons for the exception requested. You may submit a request on the CMS Model Coverage Determination Request Form available at www.bcbsm.com/medicare/help/forms-documents.html.

Generally if your request is approved, it will be valid through the end of the plan year, provided your doctor continues to prescribe the drug. If your exception is denied, you may appeal this decision. For more information about the higher level appeal procedures, contact BCBSM or see your EOC booklet.

3. Covered Hospital Services – Request for a Longer Hospital Stay/Discharged too Soon

You may request a longer hospital stay if you feel you are being discharged too soon. Within two (2) days of your admittance to the hospital, you should have received a written notice called "An Important Message from Medicare about Your Rights." You or your authorized representative is required to sign this document. It contains information on how to request an immediate review of your discharge.

Once your discharge date is determined, you may request your inpatient hospital services to be covered for a longer time. This is considered an appeal. If you need assistance contact BCBSM Customer Service or the Michigan Medicare/Medicaid Assistance Program (MMAP).

- Medicare Plus Blue Group PPO (MAPD) Customer Service at
  (866) 684-8216

- MMAP, Inc.
  6105 W. St. Joe Highway
  Suite 204
  Lansing, MI 48917
  (517) 866-1242 or (800) 803-7174

www.mmapinc.org

4. Level 1 Appeal Process to Change your Hospital Discharge Date

Your Level 1 Appeal should be done as a "Fast Review". Contact the Quality Improvement Organization (QIO) for Michigan – Livanta.

- Customer Service (888) 524-9900
- TTY (888) 985-8775
- Write Livanta LLC
  BFCC-QIO Program
  10820 Guilford Road, Suite 202
  Annapolis Junction, MD 20701
- Website www.livantaqio.com

You must contact Livanta **before** you leave the hospital **and no later than your planned discharge date**. If you meet this deadline, you are **allowed to stay** in the hospital after your discharge date **without paying for it** while you wait for a decision on your appeal from Livanta, your Quality Improvement Organization.

However, if you do **not** meet this deadline and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the hospital care costs you received after your planned discharge date.

If you miss the deadline for contacting Livanta, you can appeal directly to MAPD (the plan).

When you contact Livanta, you must request a "Fast Review" of your discharge. Livanta will conduct an independent review of your case and is required to respond within seventy-two (72) hours (Fast Appeal time frame). This appeal does not have to be in writing. The QIO Livanta representatives will speak to you (or your representative) and your doctor. Your medical information will also be reviewed.

By noon of the day after Livanta representatives informed the Plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why it is appropriate for you to be discharged. This is called a Detailed Notice of Discharge.

Within one full day after Livanta has all the needed information, Livanta will give you an answer to your appeal. If they approve your appeal, the Plan will continue to provide your covered inpatient hospital services for as long as medically necessary. You will have to pay your share of the costs (i.e., deductibles or copays).

If Livanta denies your appeal, your inpatient hospital services will end at noon on the day after Livanta responds to your appeal. If you decide to stay in the hospital then you may have to pay the full cost of hospital care beginning after noon on the day after Livanta provides you with its answer.

5. Level 2 Appeal Process to Change your Hospital Discharge Date

If you are not satisfied and your appeal was denied and you stay in the hospital after your planned discharge date, then you can make another appeal. This Level 2 Appeal will be conducted by the QIO – Livanta.

You must request another review within sixty (60) calendar days after the day you received your Level 1 Appeal denial. They will review their decision on your first appeal. Within fourteen (14) calendar days of receipt of your second appeal, Livanta will respond to your request.

If the QIO approves your appeal, then BCBSM must reimburse you for its share of the costs of hospital care you received since noon on the day after the date your first appeal was denied by Livanta. Your inpatient hospital care must continue for as long as it is medically necessary. You must continue to pay your portion of the costs.

If Livanta denies your Level 2 appeal, you will receive a written explanation as to how to appeal to Level 3, which is handled by an Administrative Law Judge or attorney adjudicator.

For more information about Levels 3, 4 and 5, please see "Level 3 and Beyond for Medical Services" above. You will follow those procedures if you decide to continue to appeal and your appeals are denied.

For additional information about other types of appeals please see your Evidence of Coverage Booklet.

SECTION 23: DENTAL BENEFITS – DELTA DENTAL

These benefits are for Active/Active Self-Pay, Retirees/Early Retirees, Totally & Permanently Disabled Retirees and Surviving Spouses, including eligible family members.

This is intended as an easy-to-read summary of your dental benefits and provides only a general overview. It is not a contract. Additional limitations and exclusions may apply. Detailed information can be found in your Delta Dental Certificate. This Summary of Dental Plan Benefits describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, contact Delta Dental's Customer Service department at (**800) 524-0149 or access their website at** www.**deltadentalmi.com.** If there is a conflict in language between the Certificate and this Summary, the Certificate controls.

You can also easily verify your benefit, claim and eligibility information online 24 hours a day, seven days a week by selecting the link for Delta Dental's Consumer Toolkit. The Consumer Toolkit will allow you to print claim forms, ID cards, review on-line Explanation of Benefits (EOB) statements, search the directory for a dentist and research oral health care tips.

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan.

What are my choices and what is the difference between a Delta Dental PPO and a Delta Dental Premier Dentist:

You have a choice of using either a Delta Dental PPO or Delta Dental Premier Dentist or a non-participating dentist. Your out-of-pocket costs will depend on your choice of dentist for services.

Delta Dental PPO Dentists
Delta Dental PPO dentists have agreed to accept the lowest payment amount (in other words greater discounts) as payment in full under Delta Dental's Fee Schedule. Additionally, PPO dentists cannot balance bill for amounts above the Delta payment for approved services. This means that your out-of-pocket costs may be less when using a Delta Dental PPO dentist and that your dental benefit maximum could purchase even more services.

Delta Dental Premier Dentists
If you go to a Delta Dental Premier dentist (a **non-PPO** dentist), you can still have lower out-of-pocket costs while using your dental benefits wisely. Premier dentists receive a higher payment (lower discount) than a Delta Dental PPO dentist, but Premier dentists also agree to accept the Delta payment as payment in full and to not balance bill for approved services.

Non-participating Dentists
If you go to a non-participating dentist (that is, a dentist who does not participate in the Delta Dental PPO or Delta Dental Premier® program network), you may have greater out-of-pocket costs. Delta Dental's payment for covered services will be based on the dentist's submitted fee or the scheduled fee or the Delta Dental Non-participating fee schedule, **whichever is less**.

Non-participating dentists may also balance bill you.
This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. You can obtain a copy of your Certificate by calling Delta Dental's Customer Service department at (800) 524-0149. The percentages below are applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation*.

A. Dental Benefit Plan Outline

Your plan is a Delta Dental PPO plan. The percentages below will be applied to the lesser of the dentist's submitted fee and Delta Dental's allowance for each service. Delta Dental's allowance may vary by the dentist's network participation.

Control Plan
Delta Dental of Michigan

Benefit Year
January 1 through December 31

Group Number: 12000-0001, 0002, 0003, 0004, 0005, 0006, 0007, 0099

COVERED SERVICES	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Class I - Diagnostic & Preventive			
Diagnostic and Preventive Services – includes exams, cleanings, fluoride and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	100%	100%
Class II - Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Major Restorative Services - crowns	80%	80%	80%
Other Basic Services – miscellaneous services	80%	80%	80%
Relines and Repairs – to prosthetic appliances	80%	80%	80%
Class III - Major Services			
Prosthodontic Services – includes bridges, implants, dentures and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	100% up to Lifetime Maximum		
Orthodontic Age Limit -	No Age Limit		

*****When services are received from a **non-participating** dentist, the percentage in the column indicates the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those

services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for the difference.

Annual Benefit Limit– Class I, II and III:

- $2,000 per person per Benefit Year (January – December) on all services, except surgical removal of impacted teeth, anesthesia, cephalometric films, diagnostic casts, photos and orthodontics.
- $2,000 per person per Benefit Year (January – December) on surgical removal of impacted teeth and anesthesia.

Lifetime Maximum – Orthodontics:
$2,000 per person total lifetime on cephalometric films, diagnostic casts, photos and orthodontic services - **No age Limit.**

Note: Services provided under the BCBSM Dental Plan prior to January 1, 2022 are included in Delta Dental's lifetime maximum.

Payment for Orthodontic Services:
When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on thirty percent (30%) of the Maximum Payment for Orthodontic Services as set forth in the Summary of Dental Plan Benefits. Delta Dental will make additional payment as follows:

- Delta Dental will pay 100% of the monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

B. Annual Service Maximums and Guidelines

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for individuals age eighteen (18) and under.
- Bitewing X-rays are payable twice per calendar year and full-mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per three (3) year period for first and second permanent molars for individuals age nineteen (19) and under. The surface must be free from decay and restorations.

- Veneers are payable on incisors, cuspids once per tooth in any five (5) year period for people age twelve (12) and older.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are covered services on posterior teeth.
- Root canal treatment is payable once per tooth per twelve (12) month period.
- Localized delivery of chemotherapeutic agents and exposure of the anatomical crown are Covered Services.
- Frenulectomy and removal of lateral exostosis are Covered Services
- Reline and rebase of dentures and tissue conditioning is payable once in any three (3) year period.
- Implants are payable once per tooth per lifetime for teeth 2 through 15 and 18 through 31. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five (5) year period. Services related to crowns over implants are Covered Services. Recement of an implant supported prosthetic is payable three times in any calendar year.
- Occlusal guards are covered services once per twelve-month period. Five limited occlusal adjustments are covered services in any five-year period.
- Therapeutic parenteral drugs and IV conscious sedation are Covered Services.

Coordination of Benefits (COB)
If you and your Spouse are both eligible under this Plan, you may be enrolled as both an Enrollee on your own application card and as a Dependent on your Spouse's application card. Your dependent children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage. See Coordination of Benefits for additional rules.

C. Exclusions and Limitations

1. Exclusions

The following is a list of common exclusions that may apply to your benefit plan. This list is not all inclusive. Additional exclusions may apply and can be found in your applicable Delta Dental certificate.

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility.

- Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. **Note:** This provision does not apply to any programs provided under Medicaid or Medicare.

- Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
- Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
- Services completed or appliances completed before a person became eligible under this Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
- Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/solutions, and relative analgesia.
- General anesthesia and intravenous sedation for:
    - Surgical procedures, unless medically necessary
    - Restorative dentistry
- Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
- Charges for failure to keep a scheduled visit with the Dentist.
- Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
- Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
- Services or supplies, as determined by Delta Dental, which are specialized techniques.
- Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
- Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
- Services or supplies received due to an act of war, declared or undeclared or terrorism.
- Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
- Services or supplies that are not within the categories of benefits selected by your employer or organization and that are not covered under the terms of the Delta Dental Certificate.
- Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
- Interim caries arresting medicament.
- Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
- Sealants.
- Space maintainers for maintaining space due to premature loss of anterior primary teeth.
- Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
- Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
- Veneers.
- Prefabricated crowns used as final restorations on permanent teeth.
- Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from

attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between Delta Dental and the Contractor.

- Implant/abutment supported interim fixed denture for edentulous arch.
- Soft occlusal guard appliances.
- Paste-type root canal fillings on permanent teeth.
- Replacement, repair, relines, or adjustments of occlusal guards.
- Chemical curettage.
- Services associated with overdentures.
- Metal bases on removable prostheses.
- The replacement of teeth beyond the normal complement of teeth.
- Personalization or characterization of any service or appliance.
- Temporary crowns used for temporization during crown or bridge fabrication.
- Posterior bridges in conjunction with partial dentures in the same arch.
- Precision attachments and stress breakers.
- Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration, and periodontal or implant bone grafting.
- Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
- Diagnostic photographs and cephalometric films unless done for orthodontics and orthodontics are a Covered Service.
- Myofunctional therapy.
- Mounted case analyses.
- Any and all taxes applicable to the services.
- Processing policies that may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating dentists may not charge Members for these services or supplies. All charges from non-participating dentists for the following are your responsibility:

- Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
- The completion of forms or submission of claims.
- Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
- Caries risk assessment performed on a Member age two (2) or under.
- Local anesthesia.

- Acid etching, cement bases, cavity liners, and bases or temporary filings.
- Infection control.
- Temporary, interim, or provisional crowns.
- Gingivectomy as an aid to the placement of a restoration.
- The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
- Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
- Palliative treatment, when any other service is provided on the same date except x-rays and tests necessary to diagnose the emergency condition.
- Post-operative x-rays, when done following any completed service or procedure.
- Periodontal charting.
- Pins and preformed posts, when done with core buildups.
- Any substructure when done for inlays, onlays, and veneers.
- A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same dentist or dental office on the same day as completed root canal treatment.
- Pulpotomy on a permanent tooth, except on a tooth, with an open apex.
- A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
- Retreatment of a root canal by the same dentist or dental office within two (2) years of the original root canal treatment.
- A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
- Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
- Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within thirty 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
- Full mouth debridement when done within thirty (30) days of scaling and root planing.
- Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within twelve (12) months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
- Full mouth debridement, when done on the same day as comprehensive evaluation.
- A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
- An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.

- Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
- Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
- Periapical and/or bitewing x-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth x-rays, as determined solely by Delta Dental.
- Processing policies that may otherwise exclude payment by Delta Dental for services or supplies.

2. Limitations

The following is a list of common limitations that may apply to your benefit plan. This list is not all inclusive. Additional limitations that may apply and can be found in your applicable Delta Dental certificate.

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in Delta's records with any Delta Dental Plan or, at the request of your Contractor, any dental plan:

- Bitewing x-rays are payable once per calendar year unless a full mouth x-ray which include bitewings has been paid in that same year.
- Panoramic or full mouth x-rays (which may include bitewing x-rays) are payable once in any five-year period.
- Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
- Oral examinations and evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.
- Patient screening is payable once per calendar year.
- Preventive fluoride treatments are payable twice per calendar year for people age eighteen (18) and under.
- Bilateral space maintainers are payable once per arch in a lifetime for people age thirteen (13) and under.
- Unilateral space maintainers are payable once per quadrant in a lifetime for people age thirteen (13) and under.
- A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age eight (8) and under.
- Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.

- Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
- Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.
- Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age eleven (11) and under.
- Hard full or partial occlusal guards are payable once in a lifetime.
- An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age seventeen (17) or during the healing period for people age seventeen (17) and over.
- Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a thirty-six (36) month period.
- Prosthodontic Services Limitations:
    - One complete upper and one complete lower denture are payable once in any five-year period.
    - A removable partial denture, implant, or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    - Fixed bridges and removable partial dentures are not payable for people age fifteen (15) and under.
    - A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
    - Implant removal is payable once per lifetime per tooth or area.
    - Implant maintenance is payable once per twelve-month period.
    - Removal of a broken implant retaining screw is payable on in a five (5) year period.
- Orthodontic Services Limitations if covered under your Plan pursuant to your Summary of Dental Plan Benefits):
    - Orthodontic services are payable for individuals pursuant to the age limits specified in your Summary of Dental Plan Benefits.
    - If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
    - Upon written notification to Delta Dental and to the patient, a dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
- Delta Dental's obligation for payment of benefits ends on the last day of coverage. However, Delta Dental will make payment for covered services provided on or before the last day of coverage as long as Delta Dental receives a claim for those services within one year of the date of service.
- When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that

the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.

- Care terminated due to the death of an Eligible Person will be paid to the limit of Delta Dental's liability for the services completed or in progress.
- Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental will make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

- Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth. Delta Dental will pay only the amount that it would pay for a full metal crown.
- Overdentures - Delta Dental will pay only the amount that it would pay for a conventional denture.
- Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
- Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
    - All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
    - Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    - Gold foil restorations, - Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
    - Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
- Maximum Payment - All benefits available under this Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
- If a deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the deductible applies until the deductible amount is met.
- Caries risk assessments are payable once in any thirty-six (36) month period for individuals age three (3) to eighteen (18).
- Assessments of salivary flow by measurement are payable once in any thirty six (36 month period.
- Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any twenty four (24) month period.

- A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
- Processing policies that may limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Eligible Persons for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your Contractor, any dental plan:

- Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
- Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
- Recementation of a crown, onlay, inlay, space maintainer, or bridge within six (6) months of the seating date.
- Retention pins are payable once in any two (2) year period. Only one substructure per tooth is a Covered Service.
- Root planing is payable once in any two (2) year period.
- Periodontal surgery is payable once in any three (3) year period.
- A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
- Tissue conditioning is payable twice per arch in any three-year period.
- The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
- Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
- Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any twenty four (24) month period when performed by the same office.
- A sealant, sealant repair, preventive resin restoration or interim caries arrenting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
- A sealant, sealant repair or preventive resin restoration is not payable when performed within twenty four (24) months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
- One caries risk assessment is allowed on the same date of service.

- One caries risk assessment is allowed within a twelve (12) month period when done by the same/dental office.
- One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same dentist/dental office.
- Processing Policies may limit Delta Dental's payment for services or supplies.

D. Coordination of Benefits

Coordination of Benefits ("COB") applies when an eligible person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this Plan's benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary
To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the eligible person to this Plan's Subscriber as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another plan that does not coordinate benefits, your other plan will always be primary.

2. Enrollee v. Dependent Coverage

The plan that covers the eligible person other than as an eligible dependent. For example, the plan that covers you as an eligible member is usually primary. However, if the eligible person is a Medicare beneficiary, federal law may reverse this order.

3. Children (Parents Divorced or Separated)

If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If a court decree states that the parents have joint custody without stating which parent is responsible for the child's health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

If neither of these rules applies, the order will be determined as follows:

- First, the plan of the parent with custody of the child;
- Then, the plan of the Spouse of the parent with custody of the child;
- Next, the plan of the parent without custody of the child; and
- Last, the plan of the Spouse of the parent without custody of the child.

4. Children and the Birthday Rule

The plan of the parent whose birthday is earliest in the calendar year is always primary for children. For example, if your birthday is in January and your Spouse's birthday is in March, your plan will be primary for all of your children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Laid Off or Retired Employees

The plan that covers the eligible person as a laid off or retired employee or as a dependent of a laid off or retired employee.

6. COBRA Coverage

The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA).

Other Plans
If none of the rules above determines the order of benefits, the plan that has covered the eligible person for the longer period will be primary.

If the other plan does not have rule 5 and/or rule 6 (above) and decides the order of benefits differently from the Delta Plan, the Delta Plan may ignore either of those rules. .

In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures for determining which plan is primary, unless prohibited by applicable law.

How Delta Dental Pays as Primary Plan
When Delta Dental is the primary plan, it will pay for covered services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan
Unless there is a Coordination of Benefits or non-duplication of benefits stated in your Summary of dental Plan Benefits, when Delta Dental is the secondary plan, it will pay for Covered Services

based on the amount left after the primary plan has paid. Delta Dental will not pay more than the secondary balance and will not pay more than Delta Dental would have paid as the primary plan.

When Benefits are reduced as described above, each benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of this plan.

Right to Receive and Release Needed Information
Delta Dental needs certain facts to apply these COB rules and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person regarding the claim being coordinated. Delta Dental need not tell or get the consent of any person to do this. Each person claiming benefits under this plan must give Delta Dental any facts it needs to pay the claim.

Facility of Payment
A payment made under another plan may include an amount that should have been paid under this plan. If it does, Delta Dental may pay that amount to the organization that made the payment.

That amount will then be treated as though it were a benefit paid under this plan, and Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, Delta Dental may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the member.

Payment includes the reasonable cash value of any benefits provided in the form of services.

E. Reconsideration and Claims Appeal Procedure

Reconsideration
If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to:

Customer Service
P.O. Box 9089
Farmington Hills, MI 48333-9089.

When writing, please enclose a copy of your Explanation of Benefits (EOB) and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your Claim was improperly denied and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within one hundred eighty (180) days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Subscriber's Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The review will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental

health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within sixty (60) days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When the Contractor advises Delta Dental to terminate your coverage.
- On the first day of the month for which the Plan Administrator has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any Claim.
- For your Dependent, when they no longer qualify as a Dependent.
- For any other reason stated in the contract between Delta Dental and the Contractor.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage

provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or comparable, non-preempted state law.

F. Continuation of Coverage

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?
Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

- Your employment, if applicable, ends for any reason other than your gross misconduct.
- You do not qualify as an Enrollee as set forth in your Summary of Dental Plan Benefits.
- You are divorced or legally separated.
- You die.
- Your Dependent is no longer a Dependent.
- You become enrolled in Medicare (if applicable).
- You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

G. General Conditions

Assignment
Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement
To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

- Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the Covered Services that were paid for by Delta Dental,
- Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
- Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
- Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
- Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information
While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship
Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment
If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission
Delta Dental will make no payment for services or supplies if a Claim for such has not been received by Delta Dental within one year following the date the services or supplies were

completed. In the event a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will Disallow the Claim. However, in the event a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract
No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions
You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least sixty (60) days written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status
You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law
This Certificate and the underlying group contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud
If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, Delta Dental may recover that payment from you or your Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits
If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Fraud Information
Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement is guilty of insurance fraud. Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call Delta Dental's toll-free hotline. Delta only accept anti-fraud calls at this number:

ANTI-FRAUD TOLL-FREE HOTLINE – (800) 524-0147

SECTION 24: ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT AND DEATH BENEFIT FOR ACTIVE EMPLOYEES

A. Accidental Death & Dismemberment (AD&D) Benefit for Active/Active Self-Pay Employee

As an Active Employee, you are eligible for Accidental Death & Dismemberment Benefits. When a bodily injury caused solely through external, violent or accidental means, on or off the job, occurs while you are an active employee, (that is when you are eligible by either Employer Contributions or self-payments) the Plan will pay benefits for losses described in the following schedule. This AD&D benefit is in addition to any other benefits that may be payable by the Plan. And, this benefit is not subject to COB provisions.

LOSS OF	
Life.	$8,000
Both Hands or Both Feet	$4,000
One Hand and One Foot	$4,000
One Hand or One Foot & Entire Sight of One Eye.	$4,000
One Hand or One Foot	$2,000
Entire Sight of One Eye.	$2,000
Entire Sight of Both Eyes	$4,000

With reference to hand or foot, "Loss" means complete severance through or above the wrist or ankle joint. With reference to eye, "loss" means the irrecoverable loss of the entire sight of the eye. Benefits will not be paid for more than one of the losses (the greatest) sustained by you as the result of any one (1) accident.

No AD&D Benefit is payable if you were engaged in a felonious activity or an aggravated assault that resulted in your loss of a limb or death. Similarly, no AD&D Benefit is payable for your suicide or attempted suicide.

Note: The Fund Office must receive written notice of your death within one (1) year of the date of death. If this filing deadline is missed, no death benefit is payable.

B. Death Benefit for Active/Active Self-Pay Employees

As an Active Employee, you are eligible for a Death Benefit upon your death, the death of your Spouse, or the death of your Eligible Dependent(s) who are at least thirty (30) days of age at the time of death. These individuals are "Covered Persons". The Death Benefit schedule is as follows:

- Active Employee $8,000
- Spouse $4,000
- Eligible Dependent Child(ren)* $2,000

*Eligible dependents are covered through the end of the month they turn age twenty-six (26). This includes disabled dependent children.

No death benefits are payable if the Covered Person was engaged in a felonious activity or an aggravated assault that resulted in death.

Note: You must provide the Fund Office with written notice of the death of a Covered Person within one (1) year of the date of death. If you miss this filing deadline, no death benefit is payable.

Surviving Spouse and Eligible Dependent(s) death benefits cease upon the death of the Active Employee.

C. Designating a Beneficiary for AD&D and Death Benefits

Once you become initially eligible for Plan benefits, you should designate a "beneficiary" for death benefits by completing the form provided to you by the Fund Office termed Beneficiary Designation Card. You may thereafter change your designated Beneficiary at any time, by filing a new, completed Beneficiary Designation Form/Card with the Fund Office. Your change of Beneficiary is effective upon receipt in the Fund Office of your newly completed Beneficiary Designation Form/Card.

If, for some reason, you've not designated a Beneficiary, **(or you do not have a beneficiary designated)** any benefits payable upon your death will be paid as follows:

- to your surviving legal Spouse, if you have one;
- if you have no surviving legal Spouse, benefits will be paid **equally** to your surviving child(ren);

- if you have no surviving child(ren), your Death Benefit is paid to your surviving parents
- if you have no surviving parents, your Death Benefit is paid to your estate

You are automatically deemed to be the Beneficiary for the payment of any benefits upon the death of your legal Spouse and Eligible Dependents. Your Spouse is not entitled to designate a Beneficiary under the Plan.

A designated Beneficiary of your Death Benefit may direct payment of your Death Benefit to the funeral home.

Your Beneficiary must submit a written claim for your Death Benefit within one (1) year from the date of your death.

SECTION 25: RETIREE DEATH BENEFITS

Retiree death benefits are payable to the beneficiary upon the death of a Retiree, the Retiree's Spouse or Retiree's Eligible Dependent(s) who is at least thirty (30) days of age according to the following schedule:

Participant	$4,000
Spouse	$2,000
Dependent Child(ren)	$2,000

Note: Surviving Spouse and Eligible Dependent(s) death benefits cease upon the death of the Retiree**.**

As of the date of death, the Retiree must have been:

- A member in good standing with the local union. Participating status will be checked upon retirement and once each year thereafter.
- Continuously remitting self-payments under either the Retiree or Early Retiree Self-Payment Program or the Totally and Permanently Disabled Retiree Self-Payment Program that provides Plan benefits for a Spouse and/or Eligible Dependents in order for their spouse to be covered for the Retiree Spouse's Death Benefit.

Special Provisions:

- Retirees should **verify that a Beneficiary Designation Card** has been completed **and is on file at the Fund Office**. This card is used to **verify who you have** designate**d** as **your** beneficiary. **A Retiree is automatically the beneficiary for a deceased Spouse.**

Note: Only the Retiree can designate a beneficiary (a Spouse cannot designate a beneficiary).

- Benefits will be paid to the beneficiary designated on the most recent Beneficiary Designation Card on file in the Fund Office on the date of death.
- In the event the Retiree has not filed a Beneficiary Designation Card, benefits will be paid in the following order:
  - to the legal surviving Spouse;
  - if the Retiree is not survived by a Spouse, benefits will be paid, equally, to any surviving children;
  - if the Retiree is not survived by either a Spouse or children, benefits will be paid to the Retiree's surviving parents;
  - if the Retiree is not survived by a Spouse, children or parents, benefits will be paid to the Retiree's estate or an individual(s) determined by the Board of Trustees to be equitably entitled to receive Death Benefits.
- 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.
- A written claim for benefits must be made within one (1) year from the date of death.

SECTION 26: NON-MEDICAL CLAIMS AND APPEALS

In General
This section is for general claims and appeals involving **eligibility** for Plan benefits (medical, disability, AD&D and death benefits).

Note: For appeal procedures involving health care services, see Section 16 for medical benefits, Section 21 for MAPD and Section 23 for dental benefits.

All claims and appeals must be in writing. You may have an authorized representative. The Fund requires your authorized representative to complete an Authorized Representative Form. Contact the Fund Office to request one.

When you submit a claim for benefits to the Fund Office, the Fund Office will determine your eligibility and/or the amount of your benefits, if any.

If the Fund Office cannot decide your claim due to special circumstances or an incomplete application, the Fund Office will notify you of the delay and may also ask you to supply the information needed to complete your application.

If the Fund Office denies your claim for any reason, either entirely or in part, the Fund Office will provide you with a written explanation for the denial of your claim. The explanation will contain the following information:

1) the specific reason(s) why the Fund Office denied your claim;

2) references to specific Plan provisions on which the denial was based;

3) a description of additional information, if any, required to complete your application, and an explanation as to why the information is necessary;

4) notice that you are entitled to receive, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits; and

5) steps you may take to appeal the decision and your right to sue the Fund if you believe that your claim was improperly denied.

If you disagree with the Fund Office's decision on your claim, you have the right to appeal that decision to the Trustees for further review as follows.

1) Within sixty (60) days after you receive the final notice denying your claim, you must notify the Fund Office *in writing* that you want the Trustees to review your claim. Your written request for review should include all information regarding your claim as well as the reason(s) why you believe the Fund Office made an incorrect decision.

2) Mail your appeal to:

Laborers' Metropolitan Detroit Health Care Fund
Attn: Appeals Committee
6525 Centurion Drive
Lansing, MI 48917
Telephone (800) 228-0048
Telephone (517) 321-7502
FAX 517-321-7508

3) You are entitled to receive information from the Fund records which you reasonably believe might help support your claim. Upon request, the Fund Office will provide you with copies of pertinent records regarding your claim at no cost to you. The Trustees' review will consider all comments, documents, records and other

information you or your representative submit regardless of whether that same information was submitted to and considered by the Fund Office.

4) If the Trustees grant you a personal hearing, you may appear in person or choose a representative to appear on your behalf.

5) If the Trustees do not grant or you do not wish to make a personal appearance before the Trustees, the Plan's Administrative Manager will present your written statement and other pertinent information to the Trustees.

6) The Trustees, or a Committee appointed by the Trustees and authorized to act on their behalf, will review your request and notify you of their decision.

7) You will receive written notice of the Trustees' decision with the reason(s) for their decision and reference(s) to specific Plan provision(s) supporting their decision. You also will be notified of your right to a reasonable review, to obtain, free of charge, copies of all documents, records and other information relevant to your claim for benefits, an explanation of the Fund's remaining voluntary appeal procedures, and your right to sue the Fund if you still believe that your claim was improperly denied.

If you need assistance with your appeal, contact the Fund Office.

SECTION 27: MISCELLANEOUS PLAN PROVISIONS

A. The Trustees Interpret the Plan

Under the Fund's Trust Agreement, and the Plan's terms, the Board of Trustees have the sole authority to interpret the Trust Agreement and the Plan, and to make final determinations regarding any benefit application and to interpret the Plan and any administrative rules adopted by the Trustees (except to the extent this authority has been delegated to the Fund Office and BCBSM). The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Trust, and the Plan documents so provide, that such decision is to be upheld unless the Court determines the decision is arbitrary or capricious.

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

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

B. Plan Amendments

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

The Trustees hope to maintain the Plan's present level of benefits and to improve upon them, if possible. But, the Trustees must protect the Plan's financial soundness at all times. This duty requires changes from time to time.

Changes in the Plan may also be required to preserve the Fund's tax-exempt status under IRS rules and regulations. These IRS rules and regulations may change. So, the Trustees may have to change Plan provisions to retain the Trust's tax-exempt status and to comply with changes in the law.

Finally, as explained earlier, the Trustees have the authority to amend the Plan's terms, change or eliminate benefits (with or without notice), or to terminate the Plan completely.

C. Plan Termination

Although the Trustees do not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. The Trustees determine that the Trust Fund assets are not adequate to carry out the purpose for which the Fund is intended; or
2. There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer Contributions to be made to the Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Trust Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be used to continue Plan benefits after the Plan termination date for those persons eligible when the Plan was terminated.

Upon written request, you may examine the agreement at the Fund Office or other specified locations or you may request a copy of the agreement, which will be provided for a reasonable charge.

D. Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to anyone else except under limited circumstances (*e.g.*, Qualified Medical Child Support Order or assignment to your health provider).

E. Tax Exempt Status

The IRS has classified the Fund as an IRC Section 501(c)(9) VEBA Trust. This means that the Employers' contributions to the Trust are tax deductible.

Also, in most cases, the benefits paid on your behalf are not taxable as personal income. Similarly, the investment earnings on Plan assets are not taxed because they are specifically set aside for the purpose of providing benefits to participants.

Such tax exemption has advantages that work to the benefit of both Employers and Employees. It means that money which otherwise might be payable as taxes can be used to purchase health-care benefits and to cover the Plan's administrative expenses.

The Trustees understand these advantages and will take whatever steps are necessary to keep your Plan "qualified" as an IRS tax-exempt trust.

F. Right to Receive and Release Necessary Information

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

G. Payment of Claims

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

H. Future of the Plan

The Trustees reserve the right to change or end any of the Plan’s benefits (or discontinue the Plan) at any time. The Trustees’ decision to change or end any of the Plan’s benefits (or to discontinue the Plan) may be due to changes in the Federal or State laws governing benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or a policy involving an insurance company, or for any other reason. Any such action would be memorialized in the minutes of the Fund’s Board of Trustees’ meetings or would be taken in writing and maintained as part of the records of the Plan.

SECTION 28: YOUR ERISA RIGHTS

As a Plan participant, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as at a worksite, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event, and if your Plan, because of the size and nature of your employer, is subject to the COBRA regulations. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants

and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A – BCBSM DEFINITIONS

Medical, Pharmacy, Vision and Hearing Care

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
- A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

Accredited Hospital
A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities. (Also see the definition of "Hospital" in this section.)

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 thirty (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 thirty (30) days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or those with substance use disorder
- Skilled nursing or other nursing care

Administrative Costs
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.

Adverse Benefit Decision
A decision to deny, reduce or refuse to pay all or part of a benefit. This also includes a decision to terminate or cancel coverage.

Advanced Practice Psychiatric Nurse
A person who has a master's degree or higher in nursing and a certification in Adult Psychiatric and Mental Health Nursing or Child & Adolescent Psychiatric and Mental Health Nursing through the American Nurses Credentialing Center (ANCC).

Affiliate Cancer Center
A health care provider that has contracted with an NCI-approved cancer center to provide treatment.

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 Infusion Center
A freestanding outpatient facility that provides infusion therapy and select injections that can be safely performed in this setting.

Ambulatory Surgery
Elective surgery that does not require the use of extensive hospital facilities and support systems but is not usually performed in a physician'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 for 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 BCBSM's maximum payment level for the covered service. Deductibles, coinsurance and/or copayments that may be required of you are subtracted from the approved amount before BCBSM's payment.

For **prescription drugs**, the lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug. The drug cost, dispensing fee

and incentive fee are set according to BCBSM contracts with pharmacies. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Deductible, coinsurance and/or copayments that may be required of you are subtracted from the approved amount before BCBSM's payment.

Approved Clinical Trial
Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- A federally funded trial, as described in the Patient Protection and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the FDA (FDA)
- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Care Act

Approved Substance Abuse Treatment Program
A residential or outpatient program that provides medical or other services for substance abusers, meets all state licensure and BCBSM approval requirements, and has entered into an agreement with BCBSM to provide those services.

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:

- Within a facility (such as a hospital and other inpatient facility)
- As part of a treatment program
- In a clinic or private office setting

The attending physician may be responsible for coordination of care delivery by other physicians and/or ancillary staff.

Audiologist
A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems. They may dispense and fit hearing aids as part of a comprehensive rehabilitative program.

Audiometric Examination
A procedure to evaluate the patient's hearing and measure hearing loss.

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 or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

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.

Binaural Hearing Aids
Two electronic devices worn by the patient to amplify sound and improve hearing in both ears.

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® Participating Provider
A provider who participates with the Host Plan.

BlueCard® Program
A program that allows Blue Cross Blue Shield members 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.

Blue Cross Blue Shield Global Core 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 Distinction Total Care (BDTC)
A program that allows you to receive care management services outside the state of Michigan from a trained clinical care provider in a team effort with, and directed by, your primary care physician.

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

By Report
A written explanation from the dentist that justifies the need for a procedure.

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

Cancellation
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

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

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

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

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

Certificate
The applicable certificate which describes your benefit plan **and** any riders that amend the certificate.

Certified Nurse Midwife
A nurse who provides some maternity, contraceptive and other 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 and/or psychiatric 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 of 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.

Claim for Damages
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Clinical Licensed Master's Social Worker
A clinical licensed master's social worker who provides some mental health services and who:

- Is licensed as a clinical social worker by the state of Michigan
- Meets BCBSM qualification standards

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

Clinical Trial
A study conducted on a group of patients to determine the effect of a treatment. For purposes under the medical 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 the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

COBRA Coverage
Consolidated Omnibus Budget Reconciliation Act (COBRA) - A federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends
- You lose coverage as a dependent of the covered employee
- Another qualifying event

If you elect COBRA coverage, you pay 100 percent of the premiums, including any share the employer paid for you, plus a small administrative fee.

Coinsurance
The portion of the approved amount that you must pay for a covered drug or service. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by an audit, adjustment, or recovery.

For prescription drugs, your coinsurance is not reduced by any coupon, rebate or other credit received directly or indirectly from the drug manufacturer.

Colonoscopy
A colonoscopy is a procedure for viewing the interior lining of the large intestine (colon) using a small camera called a colonoscope.

Colony Stimulating Growth Factors
Factors that stimulate the multiplication of very young blood cells.

Conformity Test
A follow-up visit to the physician-specialist, audiologist, or hearing aid dealer who prescribed the hearing aid to verify that the patient received the prescribed hearing aid and to evaluate its effectiveness.

Congenital Condition
A condition that exists at birth.

Contact Lenses
Contact lenses prescribed by a physician or optometrist to correct or improve vision. They are fitted directly to the patient's eye.

Continuity of Care
Seamless, continuous care rendered by a specific provider that if interrupted, could have negative impacts on the specific condition or disorder for which the patient is being treated. Continuity of care also includes ongoing coordination of care in high risk patients that have multiple medical conditions.

Contraceptive Counseling
A preventive service that helps you choose a contraceptive method.

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

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

Contract
Any applicable certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Contracted Area Hospital
A BCBSM participating hospital located in the same area as a noncontracted area hospital.

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 thirty (30) months.

Copayment
The dollar amount that you must pay for a covered service or drug. Your copayment is not altered by an audit, adjustment, or recovery. For prescription drugs, your copayment is not reduced by any coupon, rebate or other credit received directly or indirectly from the drug manufacturer. A separate copayment is not required for covered disposable needles and syringes when dispensed at the same time as insulin or chemotherapeutic drugs. For a prescription drug, your copayment may be reduced by one-half (1/2) for the initial fill (15 days) of select specialty drugs once applicable cost sharing has been met.

Cosmetic Drugs
Prescription drugs that are used primarily for improving appearance rather than for treating a disease.

Cost Sharing
Deductibles, coinsurance and/or copayments that you must pay under any certificate.

Course of Treatment
A planned program of services for the treatment of a dental condition diagnosed by a dentist as the result of an oral examination. A course of treatment begins on the date a dentist first provides a service to treat the dental condition.

Covered Services
A health care service that is identified as payable. Such service must be medically necessary, as defined in the applicable certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

Covered Drugs
A FDA (FDA) approved drug, or such drugs that BCBSM designates as covered, if the following conditions are met:

- A prescription must be issued by a prescriber who is legally authorized to prescribe drugs for human use.
- The cost of the drug must not be included in the charge for other services or supplies provided to you.
- The drug is not entirely consumed at the time and place where the prescription is written.

The drug must also be approved by the FDA for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by one of the following sources:

- The American Hospital Formulary Service Drug Information

- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

Note: Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of the applicable certificate.

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, bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

"DAW" (Dispense as Written)
An instruction on a drug prescription by a prescriber that requires the pharmacist to dispense only the drug named on the prescription.

Deductible
The amount that you must pay for covered services, under any certificate, before benefits are payable. Payments made towards your deductible are based on the approved amount at the time claims are processed. Your deductible is not altered by an audit, adjustment, or recovery.

For **prescription drugs**, your deductible is not reduced by any coupon, rebate or other credit received directly or indirectly from the drug manufacturer.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.

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

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 Services
Services that BCBSM determines only a noncontracted area hospital is equipped to provide.

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

Developmental Condition
A condition that can delay or completely stop the normal progression of speech development. Speech and language pathology services may not help these conditions.

Diagnostic Agents
Substances used to diagnose rather than treat a condition or disease.

Diagnostic Radiology
Tests used to determine the anatomic or functional state of a particular area or part of the body for the diagnosis or treatment or both of illness, disease, injury or pregnancy.

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.

Dispensing Fee
The amount BCBSM pays to a provider for filling a prescription.

Diversional Therapy
Planned recreational activities, such as hobbies, arts and crafts, etc., not directly related to functional therapy for a medical condition.

Drug List
A list of approved drugs, as determined by a group of physicians, pharmacists and other experts that review drugs for coverage determination.

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. Such equipment may be used in the home.

Ear Mold
A device made of soft rubber, plastic or nonallergenic materials, vented or non-vented, that is fitted to the outer ear canal and pinna of the patient.

Effective Date
The date your coverage begins.

Elective Abortion
Services, devices, drugs or other substances provided by any provider in any location that are intended to terminate a woman's pregnancy for a purpose other than to: increase the probability of live birth, preserve the life or health of the child after a live birth; or remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Any service, device, drug or other substance related to an elective abortion is also excluded.

Note: Elective abortions do not include: a prescription drug or device intended as a contraceptive; services, devices, drugs or other substances provided by a physician to terminate a woman's pregnancy because her physical condition, in the physician's reasonable medical judgment, requires that her pregnancy be terminated to avert her death; and treatment of a woman

Eligible Drug
An eligible drug is a brand name version of one of the prescription drugs that the Federal government requires this plan to cover but has not been prior authorized by BCBSM and is not payable by BCBSM. To qualify as an eligible drug, all the following requirements must be met:

- A prescription for the drug must be issued by a prescriber who is legally authorized to prescribe drugs for human use.
- The cost of the drug must not be included in the charge for other services or supplies provided to you.
- The drug is not entirely consumed at the time and place where the prescription is written.
- The drug must also be approved by the FDA for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by one of the following sources:
- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

Note: Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of the applicable certificate.

Eligibility
As used in any 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.

Emergency Care
Care to treat an accidental injury or medical emergency.

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

- The health of the patient (or with respect to a pregnant woman, the health of the woman or her unborn child) to be in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or unborn child)

Emergency Pharmacy Services
Drugs needed immediately because an injury or illness occurred suddenly and unexpectedly.

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

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 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 subscriber's contract.

Exigent Circumstance
An exigent circumstance exists when you suffer from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a drug that is not on BCBSM's approved drug list.

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." BCBSM is responsible for deciding if the use of any service is experimental or investigational.

Facility
A hospital or facility that offers acute care or specialized treatment, including, but not limited to, substance use disorder treatment, rehabilitation treatment, skilled nursing care or physical therapy.

Fecal Occult Blood Screening
A laboratory test to detect blood in feces or stool.

Federal Food and Drug Administration (FDA)
An agency within the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

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 any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

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

Frames
Standard frames into which two lenses may be fitted.

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.

Gender Dysphoria
A broad diagnosis that covers a person's emotional discontent with the gender he/she was assigned at birth. A clinical diagnosis is made when a person meets the specific criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Gender Reassignment Services
A collection of services that are used to treat gender dysphoria. These services may include hormone treatment and/or gender reassignment surgery, as well as counseling and psychiatric services. These services must be medically necessary to be payable by BCBSM. BCBSM will not pay for services that it considers to be cosmetic. BCBSM will also not pay for services that are experimental or investigational.

Generic Equivalent
A prescription drug that contains the same active ingredients, is identical in strength and dosage form and is administered in the same way as the brand name drug.

Group
A collection of members 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.

Hearing Aid
An electronic device worn by the patient to amplify sound and improve the patient's hearing. A hearing aid may include an ear mold, if necessary.

Hearing Aid Evaluation Test
A series of subjective and objective tests to determine what model and make of hearing aid should be prescribed to improve the patient's hearing.

Hearing Aid Dealer
A person licensed to perform audiometric examinations, hearing aid evaluation tests, conformity tests and to sell prescribed hearing aids.

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 Abuse Drugs
Drugs that affect the central nervous system and cause sedation, euphoria, or mood change.

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 or outpatient diagnostic, therapeutic, and surgical services for injured or acutely ill persons, **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 the above requirements does not qualify as a hospital under any certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include, but are not limited to, the following:

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

Hospital Privileges
Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

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. Sometimes referred to as Host Blue.

In-Network Mail-Order Provider
A provider selected by BCBSM to provide covered drugs through BCBSM's PPO program. In-network mail-order providers have agreed to accept the approved amount as payment in full for the covered drugs provided to members enrolled in BCBSM's PPO mail-order program.

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

In-network Providers
Hospitals, physicians and other licensed facilities or health care professionals who provide services through BCBSM's PPO program. This also includes ophthalmologists, optometrists, opticians or retail vision providers who have a signed an agreement with BCBSM to provide services through BCBSM's program. In-network providers have agreed to accept BCBSM's approved amount as payment in full for covered services provided under BCBSM's PPO program.

Independent Occupational Therapist
An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational 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

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

Independent Speech-Language Pathologist
A speech-language pathologist who provides some speech and language pathology services and who:

- Is licensed as a speech-language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses then a Certificate of Clinical Competence from the American Speech and Hearing Association is an acceptable alternative until the state issues licenses
- 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 and related anesthesia services
    - 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

Lenses
Glass or plastic lenses prescribed by an ophthalmologist or optometrist to correct or improve vision. They are fitted into frames.

Licensed Professional Counselor (LPC)
A licensed professional counselor who provides some mental health services and who:

- Is licensed as a professional counselor 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

Lien
A first-priority security interest in any money or other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

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

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 a LTACH.

Malocclusion
A variation from normal contact of the teeth of both jaws when closed or during movement of the lower jaw.

Mammogram
An imaging study of the breast using X-rays. This may consist of two or more x-ray views of each breast. The radiation machine must be state-authorized and specifically designed and used to perform mammography.

There are two types of mammograms:

- Screening mammograms assess patients without any signs or symptoms to assist in the early identification of breast disease.

- Diagnostic mammograms assess patients in whom signs and symptoms of breast disease are present.

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.

Maximum Allowable Cost (MAC)
The most BCBSM will pay for certain covered drugs BCBSM has identified under their Maximum Allowable Cost Program.

Maximum Allowable Cost Drugs
Certain generically equivalent drugs BCBSM has identified under the Maximum Allowable Cost Program.

Maximum Allowable Cost (MAC) Program
A BCBSM cost containment program that encourages the use of generic drugs. The MAC Program places a cost limit on certain drugs for which a generically equivalent drug is available at a lower cost.

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

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. Emergency services treat medical emergencies.

Medical Evaluation
A procedure performed by a physician to evaluate the cause of hearing loss and to determine if the hearing loss can be improved with a hearing aid.

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.

Medical Supplies
Medically necessary quantities of medical supplies and dressings used for the treatment of a specific medical condition. Medical supplies include but are not limited to gauze, cotton, fabrics, plaster and other materials used in dressings and casts.

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

Medical necessity for payment of professional providers' and other providers' services are:

- Health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
    - 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 that is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

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

Medical necessity for payment of hospital and LTACH services means:

- Determination by BCBSM that allows for the payment of covered hospital services when <u>all</u> 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).
- **For prescription drugs**, a drug must be medically necessary to be covered, as determined by pharmacists and physicians acting for BCBSM, based on criteria and guidelines developed by pharmacists and physicians for BCBSM. The covered drug must be accepted as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or prescriber.
- In the absence of established criteria, medical necessity will be determined by physicians and pharmacists according to accepted standards and practices.

Note: See below for Medical Necessity for Vision Services**.**

Medical Necessity (or Medically Necessary)
A determination by vision specialists for BCBSM, based upon criteria and guidelines developed by vision specialists for BCBSM or, in the absence of such criteria and guidelines, based upon vision specialist review, in accordance with accepted professional standards and practices, that the service:

- Is accepted as necessary and appropriate for the patient's condition, and
- Is not mainly for the convenience of the member or provider, and
- In the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient's condition.

Note: For the purposes of medical necessity determinations only, vision specialist excludes opticians, optometrists and retail vision providers.

Medication Synchronization
A coordination process which allows you, your prescriber, and your pharmacist to synchronize your multiple maintenance prescription drugs. You, and the drugs you take, must meet specific requirements in order to synchronize your medication.

Medicare
The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

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

Monaural Hearing Aid
A single electronic device worn by the patient to amplify sound and improve hearing in one ear.

Multiple Source Brand (MSB) Drug
A brand-name drug that has a generic equivalent available.

Myofunctional
Relating to muscle function, especially in the treatment of orthodontic problems.

Newborn Care
Hospital and professional services that are provided to newborns during the initial stay following birth. This care includes the newborn examination, which must be given by a physician other than the anesthesiologist or the mother's attending physician, and routine care during the newborn's inpatient stay.

Noncontracted Area Hospital
A BCBSM nonparticipating hospital located in an area defined by BCBSM.

Nonparticipating Hospital
A hospital that has not signed a participation agreement with BCBSM to accept BCBSM's approved amount as payment in full.

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 BCBSM's payment as payment in full. Some nonparticipating providers, however, may agree to accept BCBSM's payment on a per claim basis.

Nonpreferred Brand-Name Drug
A nonpreferred brand-name drug that is on BCBSM's drug list.

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, retain 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, ortheses (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 FDA.

Online Visit
BCBSM-specified evaluation and management services delivered via the internet. Contact is initiated by you and must be within the provider's scope of practice.

Ophthalmologist
A licensed doctor of medicine or osteopathy who, within the scope of his or her license, performs eye exams and prescribes corrective lenses.

Optician
A specialist who fits eyeglasses and makes lenses to correct vision problems.

Optometrist
A person licensed to practice optometry in the state the service is provided.

Ordered
When the dentist has completed preparing the mouth for an inlay, onlay, crown, bridge or denture and has taken final impressions for the laboratory.

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 Hospital
A BCBSM participating hospital that is more than seventy-five (75) miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

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

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

Out-of-network Providers
Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under BCBSM's PPO program.

For vision services, an ophthalmologist, optometrist, optician or retail vision provider that has not signed an agreement to provide services under BCBSM's PPO program. Out-of-network providers have not agreed to accept the approved amount as full payment for covered services.

Outpatient Mental Health Facility
A facility that provides outpatient mental health services. The facility must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), the facility 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 those with substance use disorder.

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

Partial Hospitalization Program (PHP)
Treatment for mental or emotional disorders provided by a hospital or outpatient psychiatric care facility to a patient who lives at home and goes to a hospital or outpatient psychiatric care facility.

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

Participating Hospital
A hospital that has signed a participation agreement with BCBSM to accept BCBSM's approved amount as payment in full. Your cost share, which may be required of you, is subtracted from the approved amount before BCBSM's payment.

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 BCBSM's approved amount as

payment in full. Any cost-share, which may be required of you, is subtracted from the approved amount before BCBSM's payment.

Patient
The subscriber or eligible dependent that is awaiting or receiving medical care, treatment or covered drugs.

Pay-Provider Claim
This is a type of claim where BCBSM pays your provider directly according to the terms of your coverage.

Pay-Subscriber Claim
This is a type of claim where BCBSM will reimburse you, the subscriber, according to the terms of your coverage. Either you or your provider may submit this type of claim.

Per Claim Participation
Available to some nonparticipating providers when they elect to accept BCBSM's payment for specific covered services as payment in full.

Period of Crisis
A period during which a patient requires continuous care (primarily nursing care) to alleviate or manage acute medical symptoms.

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.

Pharmacy
A licensed establishment where a licensed pharmacist dispenses prescription drugs under the laws of the state or country where the pharmacist practices.

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 Therapist
A physical therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

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 retain, learn, 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." The term physician or practitioner may also include other types of professional providers when they perform services they are licensed or legally qualified to perform in the state where the services are provided.

Physician Assistant
A physician assistant is licensed by the state of Michigan to engage in the practice of medicine, osteopathic medicine and surgery, or podiatric medicine and surgery with a participating physician under a practice agreement.

Physician-Specialist
A licensed doctor of medicine or osteopathy who is also board certified or board eligible as an otologist, otolaryngologist or otorhinolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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.

Post-service Grievance
A post-service grievance is an appeal that you file when you disagree with BCBSM's payment decision or BCBSM's denial for a service that you have already received.

Practitioner
A physician (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, licensed professional counselor or oral surgeon) or other professional provider who participates with BCBSM or who is in a BCBSM PPO network. Practitioner may also be referred to as "participating" or "in-network" provider.

Preapproval
A process that allows you or your provider to know if BCBSM will cover proposed services before you receive them. If preapproval is not obtained before you receive certain services described in a certificate and/or rider, services may not be covered.

Preapproval Process
A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine-month intervals or at other mutually agreed upon intervals after the onset of treatment.

Preferred Brand-Name Drug
A preferred brand-name drug that is on BCBSM's drug list.

Preferred Provider Organization (PPO)
A limited group of health care providers, pharmacies, or dentists who have agreed to provide covered services or drugs to BCBSM members enrolled in a PPO program. These providers, pharmacies and dentists accept an approved amount as payment in full for covered services.

Pre-service Grievance
A pre-service grievance is an appeal that you can file when you disagree with BCBSM's decision not to preapprove a service you have not yet received.

Prescriber
A health care professional authorized by law to prescribe "Rx only" drugs for the treatment of human conditions.

Prescription
An order for medication or supplies written by a prescriber as defined in this section.

Prescription Drugs - Preferred Provider Organization (PPO)
A limited group of pharmacies that have been selected for this program and have agreed to provide covered drugs or services to BCBSM members and accept BCBSM's approved amount as payment in full.

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

Primary Care Physician (PCP)
The physician you choose to provide or coordinate your medical care, including specialty and hospital care. A primary care physician is appropriately licensed in one of the following medical fields:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

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.

Prior Authorization
Some services, prescription drugs and vision benefit services, require prior authorization before you receive them. If you receive them without first obtaining prior authorization, you may have to pay the bill yourself. BCBSM may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive these services.

Professional Provider
One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Physician assistant (PA)
- Fully licensed psychologist
- Limited licensed psychologist (LLP)
- Clinical licensed master's social worker (CLMSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)
- Oral surgeon
- Independent physical therapist (IPT)
- Independent speech therapist (IST)
- Independent Occupational therapist (IOT)
- Certified nurse practitioner (CNP)

- Certified nurse midwife (CNM)
- Certified registered nurse anesthetist (CRNA)
- 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.

Protocol
A detailed plan of a medical experiment or treatment.

Provider
A person (such as a physician) or a facility (such as a hospital) who provides services or supplies related to medical care; a pharmacy legally licensed to dispense drugs; a dentist or hygienist who provides services or supplies related to dental care; an ophthalmologist, optometrist, optician or retail vision provider that provides services related to vision care; a physician-specialist, audiologist or hearing aid dealer who provides services or supplies relating to a possible hearing loss.

Provider-Delivered Care Management (PDCM)
A program that allows you to receive care management services in Michigan from a trained clinical care manager in a team effort with, and directed by, your primary care physician.

Psychiatric Residential Treatment Facility
A facility that provides residents with twenty-four (24) hour mental health care and treatment, seven days a week. The facility must participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

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.

Quadrant
Dental arches are divided into equal sections known as quadrants. A quadrant begins at the mid-line (center teeth) of the arch and extends back to the end of the upper or lower jaw.

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).

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

- The referring provider participates in the trial and has concluded that the individual's participation in the trial would be appropriate because the individual meets the trial's protocol; or
- The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols.

Qualifying Event
One of the following events that allows you to enroll in different health care coverage or change your current coverage or allows a beneficiary to receive coverage under COBRA:

- Termination of employment (other than for gross misconduct) or reduction of hours
- Start of Military Service. Members must perform military duty for more than thirty (30) days
- 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

NOTE: The examples in this definition are not exhaustive and may change. Call BCBSM Customer Service or your Fund Office for more information about qualifying events.

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

Referral
The process in which the Primary Care Physician (PCP) sends a patient to another provider for a specified service or treatment plan.

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

Registered Provider
A participating or nonparticipating provider that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Reimbursement
The amount BCBSM pays for a covered procedure. BCBSM's reimbursement is based on the lesser of the amount billed or the BCBSM maximum payment level for that procedure on the date the service is provided, minus any cost-sharing you are required to pay.

Relapse
When a disease recurs after a period of time following therapy. The 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 subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber; and
- Pay the subscriber's BCBSM bill

Rescission
The cancellation of coverage that is back dated to the effective date of the member's contract and voids coverage during this time.

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 on a residential basis specifically for those with substance use disorder in a facility that operates twenty-four (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.

Retail Health Clinic
A medical clinic located inside a retail store which offers "walk-in" care for minor conditions, provided by a professional provider.

Retail Vision Provider
A retail vision provider is a chain of four or more stores providing vision services. A retailer may be in-network or out-of-network.

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
    - Reversible appliance therapy (mandibular orthotic repositioning).

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

Right of Recovery
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.

Routine Patient Costs
All items, services and prescription drugs related to an approved clinical trial if they are covered under any certificate (or any riders that amend a certificate) for members who are not participants in an approved clinical trial. They do not include:

- The investigational item, device, or service itself,
- Items, services and prescription drugs provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or
- An item, service or prescription drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sanctioned Prescriber
Any provider who has been disciplined under Section 1128 and Section 1902(a) (39) of the Social Security Act; excluded or suspended from participation in Medicare or Medicaid; whose license to issue prescriptions has been revoked or suspended by any state licensing board; or whose prescribing habits have been determined by BCBSM to deviate significantly from established standards of medical necessity.

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.

Select Controlled Substances
Specific medications identified by BCBSM as requiring limits on the quantity dispensed or the day supply. These medications are regulated by state and/or federal laws that aim to control the danger of addiction, overuse, physical and mental harm, death, trafficking by illegal means, and other harms. A list of these medications is available at bcbsm.com/pharmacy.

Select Over-the-Counter (OTC) Drugs
Over-the-counter drugs identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's prescriber. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Select Prescription Drugs Requiring Prior Authorization
Prescription drugs identified by BCBSM as requiring prior authorization. A description of the drugs and the criteria for approval are provided in a list that is updated periodically by BCBSM. Your prescriber or pharmacist can call BCBSM for this list. Select prescription drugs do not include antineoplastic drugs or drugs needed to treat an immediate life-threatening condition.

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, procedures or equipment given by a health care provider to diagnose or treat a disease, injury, condition, pregnancy or to diagnose or treat dental conditions.

Short Fill Period
A shorter prescription drug fill time period. For example, a normal fill for your prescription could be thirty (30) days. A short fill period would be to fill your prescription for fifteen (15) days. This short fill period is used to synchronize medications or to avoid waste when trying new medications.

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 Medical Foods
Special foods that are formulated for the dietary treatment of inborn errors of metabolism. The nutritional requirements of the patient are established by a physician's medical evaluation of the patient. The diet must be administered under the supervision of a physician.

Specialist
A provider with a specific skill or expertise in the treatment of a particular condition or disease. The patient is referred to a specialist by his or her Primary Care Physician (PCP).

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. Select specialty pharmaceuticals require prior authorization from BCBSM.

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

Note: BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

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.

Spouse
An individual who is legally married to the subscriber and meets the group's eligibility requirements.

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)).

State-Controlled Drugs
Drugs that are usually sold over-the-counter but require a prescription under state law when certain quantities are dispensed.

Step Therapy
Previous treatment with one or more preferred drugs may be required.

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
Subrogation occurs when BCBSM assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

Subscriber
The person who signed and submitted the application for coverage.

Substance Abuse Treatment Program Services
Subacute services to restore a person's mental and physical well-being when the person has a substance use disorder. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

Substance Use Disorder
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 as reflected by alterations of thought, mood, cognition, or behavior
- Endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Substance use disorder is alcohol or drug abuse, or dependence as classified in the most current edition of the "International Classification of Diseases."

Note: Tobacco addictions are included in this definition.

Supervision
When a dentist oversees the care of a patient, is available when necessary, but is not at chairside while service and treatment are rendered.

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, must be approved by BCBSM. Tandem transplants are

also referred to as dual transplants or sequential transplants. A tandem transplant is considered 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.

Telemedicine
Real-time health care services delivered via telephone, internet, or other electronic technology when you're not in your provider's presence. Contact for these services can be initiated by you or your provider and must be within your provider's scope of practice.

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

Termination
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

Therapeutic Radiology
The treatment of neoplastic conditions with radiant energy.

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 the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered 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 professional providers' offices.

Valid Application
An application for Medicare benefits filed by a member with End Stage Renal Disease (ESRD) according to the rules established by Medicare.

Vision Specialists
Licensed MDs and DOs who are board certified or board qualified in the specialty of ophthalmology, licensed optometrists, opticians and retailer vision providers.

Voluntary Sterilization
Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

VSP
Vision Service Plan©

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 in BCBSM certificates and riders when referring to Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

Used in the HIPPA Privacy Notice means the Fund.

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

Working Aged
Employed individuals age sixty-five (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 sixty-five (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 Plan.

APPENDIX B – DELTA DENTAL GLOSSARY

Adverse Benefit Determination
Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount
The amount permitted under the applicable fee schedule for this Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year
The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year, unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits
Payment for the Covered Services that have been selected under This Plan.

Certificate
Delta Dental's certificate. Delta Dental will provide benefits as described in the applicable certificate. Any changes in the certificate will be based on changes to the contract between Delta Dental and the Contractor.

Child(ren)
Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim
A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date
The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;

- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment
The percentage of the charge or flat dollar amount, if any, that you must pay for Covered Services.

Contractor
The employer, organization, group, or association sponsoring This Plan.

Covered Services
The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible
The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental
Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Member Plan
An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental Premier Dentist Schedule
The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta dental Member Plan.

Dentist
A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
- **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.

- **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Delta Dental Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists**."

Deny/Denied/Denial
When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dependent(s)
Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits

Enrollee
You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Maximum Approved Fee
The Maximum Approved Fee is the lowest of:

- The submitted amount
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Pament
The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Member(s)
Any enrollee or Dependent with coverage under This Plan.

Nonparticipating Dentist Fee
The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Out-of-Country Dentist Fee
The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

PPO Dentist Schedule
The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate
A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies
Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Spouse
Your legal Spouse.

Submitted Amount
The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Summary of Dental Plan Benefits
A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate and supersedes any contrary provision of this Certificate.

This Plan
The dental coverage established for Members pursuant to Delta Dental's Certificate and your Summary of Dental Plan Benefits.

APPENDIX C - THE BOARD OF TRUSTEES

Employer Trustees

Robert Coppersmith, **Secretary**
Michigan Infrastructure and
Transportation Association (MITA)
P.O. Box 1640
Okemos, Michigan 48805

Charles Wilson (MCA)
Monte Costello Construction
P.O. Box 7119
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Barton Malow Company
26500 American Drive
Southfield, MI 48034

Jeremy Zeller (DET AGC)
Walbridge Concrete Service
777 Woodward Ave., Suite #300
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James Oleksinski (CAM)
Construction Association of
Michigan
43636 Woodward Ave.
Bloomfield Hills, MI 48323

Ije Osuagwu (AGC)
Brix Corporation
30591 Schoolcraft Road
Livonia, MI 48150

Union Trustees

Bill Bass, **Chairman**
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760 Joslyn Avenue
Pontiac, Michigan 48340

Michael Aaron
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2161 West Grand Boulevard
Detroit, Michigan 48208

Jason Chwalek
Local Union 1076
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1118 Centennial Way, Suite 100
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Note: effective as of July 20, 2021.