MICHIGAN CARPENTERS' HEALTH CARE FUND

Summary Plan Description

November 2003

INTRODUCTION

The Trustees of the Michigan Carpenters' Health Care Fund ("Fund") are pleased to provide you and your family with this Summary Plan Description (SPD). This booklet describes the fund benefits, flex benefits, burial benefits, and accidental death and dismemberment benefits.

If you have questions concerning your or your family's eligibility for benefits, contact the Fund Office. Phone numbers are listed in the Appendix section of this booklet.

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Section 1: Eligibility and Guidelines

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

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

Active Employees

Employers must pay contributions for health care benefits based upon each hour you work.

The Fund uses a "dollar bank" eligibility system for its Active Employees Program. Under this system, once you have met the Initial Eligibility Provisions, which are explained below, you can "bank" employer contributions which are in excess of those required for you to maintain eligibility each month. For example, you have $572 of employer contributions remitted to the Fund for a particular month and need only $553 to maintain eligibility. Extra employer contributions will be "deposited" in your "bank" to be saved for you to use when, and if the amount of employer contributions for a particular month is less than the amount required to maintain your eligibility. If, for the following month only $295 of employer contributions are remitted to the Fund in your behalf, and you need $553, you will have the additional $258 withdrawn from your dollar bank to maintain your eligibility.

Once eligible, if you have insufficient contributions in your dollar bank, you will be billed for the amount of contributions you are short. You will also be given the opportunity to choose between self-contributions, alternative minimum coverage, or COBRA Continuation Self-Payments.

You may not accumulate more contributions in your dollar bank than the equivalent of the amount of contributions which would provide you with continued coverage for 12 months.

Initial Eligibility Requirements

To be initially eligible for benefits, you must have had a minimum of 140 hours multiplied by the current contribution rate of employer contributions remitted to the Fund for work performed in any month. These initial eligibility requirements apply only when you are first establishing eligibility under the Fund or if you have been continuously ineligible under the Fund for at least 24 consecutive months. Only employer contributions can be counted in meeting the initial eligibility provisions. Self-contributions are not permitted to establish initial eligibility.

Eligibility begins on the first day of the month following a two-month accounting period after the initial eligibility requirements have been met. For example, you work for a contributing employer who remits at least 140 hours of contributions at the current contribution rate for work performed by you during the month of April, you become eligible for benefits on July 1 and remain eligible for the entire month of July. Coverage for benefits is restricted to claims on and after the date eligibility begins.

If you have more than the required employer contributions remitted in the month used to satisfy the *initial* eligibility requirements, the amount in excess of that required amount for *initial* eligibility is not credited to your dollar bank.

Continuation of Eligibility

Once having become eligible, you will remain eligible if:

1. You continue to have at least 140 hours of employer contributions at the current rate made to the Fund in your behalf each month;
2. You have at least 140 hours of employer contributions at the current rate remaining in your dollar bank which can be withdrawn to meet the eligibility requirement; or
3. You have less than 140 hours of employer contributions at the current rate remaining in your dollar bank and you make a self-contribution at the then current contribution rate for the combination of employee contributions and the amount in your dollar bank in accordance with the provision governing self-contributions for Active Employees. For example, you have only $161 remaining in your dollar bank and do not have any employer contributions remitted for the month in question, you would be billed for the difference between to continue your eligibility.

If you fail to remit the required self-contribution for continued eligibility, when your dollar bank is insufficient to provide you with continued eligibility, the amount in your dollar bank will be canceled. You will be required to have contributions of at least 140 hours of employer contributions at the current rate for work performed in one calendar month to again become eligible. If you have been ineligible for 24 consecutive months or more based upon employer contributions, self-contributions or a combination of both, you must again satisfy the initial eligibility requirements to become eligible.

Upon retirement or other termination of employment, your dollar bank will be used to maintain your eligibility under the Active Employee schedule of benefits until it is exhausted, subject to all other provisions of the Plan.

Upon your death, any remaining amount in your dollar bank will be used to continue coverage for your spouse and/or dependent children without the

necessity of self-payments under the Surviving Spouse Self-Payment Program until such time as your dollar bank is exhausted.

Self-Contributions

If you are an Active Employee and you lose your eligibility because the amount of employer contributions in your dollar bank is insufficient, you may continue your eligibility by making a self-contribution in accordance with the following procedures. (You and your dependents also have the right to continue coverage under the COBRA Continuation Provisions, if the qualifications are met.)

When you are about to become ineligible, the Fund Office will attempt to notify you about three (3) weeks before the date you would otherwise become ineligible. This notice will state the amount of self-contribution required to continue your eligibility. The required self-contribution must then be post marked no later than the date indicated on the notice.

Acceptance of self-contributions from you is conditioned upon your becoming and/or remaining ineligible because of a lack of available employment as a Carpenter within the jurisdiction of the Fund or because you are currently working as a Carpenter for a contributing employer but for insufficient hours to remain eligible. Evidence you are available for work as a Carpenter within the jurisdiction of the Fund is required. If you are *temporarily* disabled, you may also remit self-contributions to continue your coverage. Evidence of this *temporary* disability is required.

All self-contributions must be made by check or money order made payable to "Michigan Carpenters' Health Care Fund" and post marked within the prescribed time to the Fund Office, 6525 Centurion Drive, Lansing, MI 48917-9275.

Self-contributions may be made by credit card as well. Please contact the Fund Office for the appropriate forms.

Keeping Track of Bank Employer Contributions

A Yellow Slip is sent to you reflecting the contributions received and/or monies remaining in your dollar bank for each month that (1) employer contributions are remitted in your behalf, (2) you remit a self-contribution and/or (3) contributions remain credited to your dollar bank. You should carefully monitor your Yellow Slips to assure that contributions from employers have been remitted in your behalf while you are employed, that self-contributions remitted were received and that the monies in excess of those needed for eligibility purposes have been credited to your dollar bank. If a discrepancy in employer contributions is noted, it is your responsibility to promptly notify the local union. If a discrepancy is noted in self-contributions or dollar bank total, the Fund Office should be contacted.

IT IS IMPORTANT that you keep the Fund Office informed of your current address. It is equally IMPORTANT that you make the required self-contribution when due even if you think you should be eligible by way of employer contributions. If the Fund later receives contributions, an appropriate refund of the self-contributions will be made by the Fund Office.

Eligibility Chart

The following chart demonstrates the month(s) you will be eligible if sufficient employer contributions are received for work performed in any given month. The chart also shows the approximate due date of self-contributions to continue coverage, if a self-contribution is required.

This schedule with approximately the same "Due Dates" will continue on a revolving basis for subsequent months and years.

Eligibility Chart

Work Month	Eligibility Month	Self-Contribution Post Marked Date
9/03	12/03	11/20/03
10/03	1/04	12/20/03
11/03	2/04	1/20/04
12/03	3/04	2/20/04
1/04	4/04	3/20/04
2/04	5/04	4/21/04
3/04	6/04	5/20/04
4/04	7/04	6/20/04
5/04	8/04	7/21/04
6/04	9/04	8/20/04
7/04	10/04	9/22/04
8/04	11/04	10/20/04
9/04	12/04	11/20/04

Alternative Minimum Coverage Program

If you are an Active employee who is maintaining eligibility by way of the Fund's regular self-contribution program, you may be eligible to participate in the Fund's Alternative Minimum Coverage Self-Payment Program. Please refer to Section 13 for a description of eligibility provisions.

COBRA Continuation Coverage

This section is intended to explain to you and your eligible dependents, in a summary fashion, about *rights and obligations* under the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or "COBRA." You, your spouse (if any), and your dependents (if any) should take time to read this section carefully.

Employee Rights

You have the right to choose continuation coverage if you lose eligibility for coverage under the Plan due to a reduction in the amount of employer contributions remitted or termination of employment for any reason, unless termination is due to gross misconduct on your part.

The Trustees, through the Fund Office, determine when a qualifying event occurs as a result of a reduction of employer contributions or a termination of employment based on information contained on submitted employer contribution forms. The Fund Office will determine when the COBRA qualifying event has occurred within 120 days following receipt of the employer contribution form. The Fund Office will mail the COBRA election notice within 60 days after it has determined that you or a qualified beneficiary has lost eligibility for 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.

Spouses of Employees or Retired Participants covered under the Plan 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 which occur on or after September 1, 1987:

- 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 or the death of a Retired Participant;
- Divorce or legal separation from you; or
- You become entitled to Medicare and are not eligible to continue coverage for your spouse under another portion of the Plan or choose not to continue such coverage.

All of your dependent children covered under the Plan have the right to continuation coverage if they lose their eligibility for coverage under the Plan for any of the following five reasons which occur on or after September 1, 1987:

- Termination of their parent's employment (for reasons other than gross misconduct) or a reduction in the number of hours worked by their parent, who is the covered Employee under the Plan;
- Death of the parent, who is the covered Employee under the Plan:
- Divorce or legal separation of their parents;
- You become entitled to Medicare and either are not eligible to continue coverage for the children or choose not to continue such coverage; or
- The child or children cease to satisfy the Plan's definition of a "dependent child."

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

Disabled Persons

If you, as a covered employee, your spouse, or any dependent child qualifies for social security disability benefits at any time during the sixty (60) days after you lose coverage for the reasons listed above, you may purchase up to an additional 11 months of COBRA (or a total of twenty-nine [29] months).

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

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

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

Although your COBRA coverage may be canceled as soon as you are covered by Medicare, a spouse or dependent child with COBRA coverage at that time may continue purchasing such coverage for up to 18 or 36 months minus any months of COBRA coverage received immediately prior to your coverage under Medicare.

This option applies only if a spouse or dependent child is not also covered by Medicare.

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

Employee Obligations

Under COBRA, you or a family member must notify the Fund Office immediately about a divorce, legal separation, or a child losing dependent status under the Plan. If such an event is not reported to the Fund Office within 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 60-day time limit will not be extended and you may lose the opportunity to elect COBRA.

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

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

COBRA coverage offered by the Plan, as of the time such coverage is provided, and is identical to the coverage provided to similarly situated beneficiaries covered by the Plan. However, Death benefits are not available through COBRA.

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

Procedure for Obtaining Continuation Coverage — Other Requirements

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 60-day time period, your right to continue your group health care coverage will end.

You do not have to show that you are uninsurable to choose continuation coverage. But, you must make the required self-payment for continuation coverage. The amount will be shown on the election notice.

If you elect continuation coverage, the Plan must provide coverage which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries for basic hospital, medical, and surgical benefits. Burial Benefits and Accidental Death and Dismemberment Benefits are not provided.

The law requires that if you lose your coverage due to a termination of employment or to a reduction in hours worked, you be given an opportunity to continue your coverage for up to eighteen (18) months. This eighteen (18) month period may be extended to twenty-nine (29) months if you are disabled (under the Social Security Act) on the date of termination or reduction in hours. A dependent may maintain coverage for up to thirty-six (36) months.

The law also provides that continuation coverage may be cancelled by the Fund for any of the following reasons:

1. The Fund no longer provides group health care coverage to any Employees
2. The required self-payment for continuation coverage is not paid on time
3. The person remitting COBRA continuation coverage payments becomes covered under any group health care plan that does not include a pre-existing condition exclusion

4. The person remitting COBRA continuation coverage payments becomes entitled to Medicare.

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

Health Insurance Portability and Accountability

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

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

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

Military Service

Effective October 13, 1994, you were entitled to continue your Fund health care coverage for up to 18 months if you stopped working in covered employment to enter the "uniformed services." You are considered to be in the uniformed

services when you are in the Armed Forces or in active duty for training, inactive duty for training, or full-time duty in the National Guard, the Air National Guard, or the commissioned corps of the Public Health Service. You may be required to pay a monthly fee to continue coverage. To assure that this coverage is provided on a timely basis, please notify the Fund Office immediately upon entry into the uniformed services. Contact the Fund Office for more details.

Special Eligibility Provisions

Self-Employed Carpenters (Sole Proprietorship and Partners)
If you are a self-employed Carpenter and have signed a Participation Agreement with the Fund, you may participate in the Plan and maintain coverage there under, by remitting contributions on your behalf at the then current contribution rates. For details, you should contact the Fund Office.

Employers may also remit health care contributions on behalf of their office or supervisory employees. Please contact the Fund Office for more information.

Reciprocity

The Trustees have entered into the International Reciprocity Agreement sponsored by the United Brotherhood of Carpenters and Joiners of America, AFL-CIO, as well as reciprocity agreements with other Health Care Funds covering Carpenters in the United States. Pursuant to these reciprocity agreements, contributions made may be transferred from one Health Care Fund to another upon your written request and authorization. The contributions which may be transferred may enable you to meet the Fund's eligibility provisions. If you work in another jurisdiction and have employer contributions made to another Fund on your behalf, you should request that such contributions be transferred, via a reciprocity agreement, to this Fund. You should contact your Local Union Office or the Fund Office to see if a reciprocity agreement exists between this Fund and such other Fund and, if it does, sign the necessary request form to effect transfer.

Both Spouses Eligible as Employees

If both you and your spouse are employed as Carpenters, and you are both eligible as Employees, coordination of benefits will be in effect for any claims incurred by either you or your spouse and for any eligible dependent children.

Extension of Benefits

Benefits otherwise payable under this Plan will also be paid, as specified in this booklet, for charges incurred during the 90 days immediately following the date you lose eligibility if you are disabled on the day immediately preceding the date eligibility was terminated and are completely and continuously disabled through the date services or supplies are provided. Coverage will be available only for

those services or supplies received that are directly related to the covered injury/illness that caused the complete and continuous disability.

Claims Incurred in Foreign Countries

Claims incurred in foreign countries are covered by the Plan, subject to all limitations of the Plan. Additional time is required to process claims submitted from foreign countries. Please contact the customer service department at Blue Cross Blue Shield or the Fund Office for further information.

Active Employees and/or Their Spouses Who Are Age 65 or Older

If you are an Active Employee and continue to work, or remain eligible via banked contributions or self-contributions, beyond the date you or your spouse becomes eligible for Medicare at age 65, you have the option to have either the Fund or Medicare as your primary payer of benefits. If you elect Medicare as the primary payer of benefits, your out-of-pocket expenses will generally be greater than they would be if the Fund is the primary payer.

Because of the additional costs to you if Medicare is the primary payer of benefits, the Trustees have decided that the Fund should be the primary payer of benefits for all **Active Employees and Their Spouses** who are over age 65 and entitled to Medicare. What this means is that in those cases where Medicare and the Fund cover the same items or services, the Fund will pay first and then Medicare will supplement the Fund's coverage up to the Medicare limit.

In most cases, the Fund's benefits are more generous than those provided under Medicare. Where they are not, you retain the right to file your claim with Medicare for whatever supplemental coverage is available. Your combined benefits from Medicare and the Fund will remain unchanged.

Any time after the age of 65 that you cease to meet the definition of an Active Employee, Medicare automatically becomes the primary payer.

If for some reason you or your spouse would rather have Medicare as the primary payer, you must state this preference in writing to the Fund Office when you become eligible for Medicare. Regardless of your election, you should not forget to pay the Part B Medicare premium for medical services for your own protection. Failure to pay the Part B premium on time will result in the loss of Medicare protection for medical services. You are considered active until you retire with one of the participating pension funds, the Social Security Administration, or cease to apply for active employment.

Active Employees with Dependents Eligible for Medicare

The Fund must act as the primary payer of benefits for any Active Employee and/or your covered family members who are eligible for Medicare due to a disability. This requirement ends when you cease to meet the definition of an Active Employee.

Claims for the Covered Persons affected by this provision are considered primary to the Fund first. Any portions not paid should then be submitted to Medicare for payment. In those cases where Medicare and the Fund cover the same items or services, the Fund will pay first up to its limits and then Medicare will supplement the Fund's coverage up to the Medicare limits. In some instances, only the Fund will provide coverage for some items.

Covered Persons affected by this provision are advised to pay the premium for Part B (Medical) coverage through Medicare. This assures the most complete coverage for medical expenses and is required to qualify for participation in certain programs available through the Fund.

Eligibility of Dependents

You dependents are eligible whenever you are eligible, provided the Dependent meets the definition of dependent. Eligible Dependents include:

- Your legal spouse.
- Your unmarried dependent child or children under the age of 19, including step-children and legally adopted children for whom you are the legal guardian and who depend on you for their living expenses and who can be claimed as your "dependent" for Federal Income Tax purposes. Coverage for adopted children begins on the date of placement, i.e., assumption and retention by the adopting parent(s) of a legal obligation for support in anticipation of adoption.
- Your unmarried dependent child or children over the age of 19 and under the age of 25, (until December 31st of the year they attain age 25) including step-children and legally adopted children, who meet the requirements as described above.
- Your unmarried dependent child or children, including step-children and legally adopted children, who are over the age of 19 and incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became incapacitated before the attainment of age 19 and who are chiefly dependent on you for support and maintenance. Coverage will be extended for these dependent children provided proof of such incapacity is furnished by you at no expense to the Fund within 31 days of the date such dependent attains the age of 19.

- Unmarried dependent children for whom the Fund is required to provide benefits under a qualified medical child support order.

The term "Dependent" does not include any person who does not meet the above definition. *Foster children are not considered dependents.*

Early Retiree Self-Payment Program

If you retire before you are entitled to Medicare Benefits, you are considered an Early Retiree with the Health Care Fund until such time as you become eligible for Medicare.

Eligibility Provisions

To continue coverage under the Health Care Fund as an Early Retiree, you must be receiving monthly pension benefits from one of the following sources:

1. The Michigan Carpenters' Pension Fund
2. The Detroit Carpenters' Pension Fund
3. The Social Security Administration.

If you are not receiving a monthly pension benefit from one of the three (3) sources listed above, you may also be eligible to participate in the program provided you have been continuously eligible via employer contributions for the three (3) years immediately preceding your retirement. Please contact the Fund Office for more information.

If you are eligible for Medicare, your coverage will be provided under the Supplement to Medicare Program, provided you meet the qualifications for that program. If you fail to meet those qualifications, no coverage will be available through the Plan.

Your dependent(s), provided they are not eligible for Medicare, may be covered through the Retiree Self-Payment Program. If your dependent(s) is/are also eligible for Medicare, coverage will be provided for such dependent(s) under the Supplement to Medicare Program, provided your dependent(s) meet the qualifications for that program. If they fail to meet those qualifications, no coverage will be available through the Plan.

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

Schedule of Benefits for Early Retirees

The schedule of benefits for you as an Early Retiree and your dependents (who are not eligible for Medicare) is the same as the schedule of benefits in effect for Active (Non-Retired) Participants, with the exception of Burial Benefits and Prescription Coverage. Early Retirees and spouses are not eligible for Accidental Death and Dismemberment Benefits. Refer to Section 4 for an explanation of Retiree Burial Benefits.

Method of Payment for Coverage

Your self-payments must be postmarked by the 20th day of the month preceding the month for which payment is being made. For example, the self-payment to provide coverage for the month of September must be postmarked no later than August 20th. Self-payments are to be made by either check or money order made payable to "Michigan Carpenters' Health Care Fund."

You may elect to have self-payments deducted from your Michigan Carpenters' Pension Fund monthly benefit check. The appropriate authorization for deduction form must be executed by the 20th day of the month preceding the month such deductions are to begin. Cancellation of the deductions must be made in writing at least 60 days before the effective date of cancellation.

Self-payments may also be remitted by credit card. Please contact the Fund Office for more information.

You may remit self-payments for up to six (6) months in advance. Upon receipt of the self-payment, the Fund Office will send only one notification to you of the due date and amount of your next self-payment. It is your responsibility to remit your next self-payment in a timely manner since no additional notifications will be sent.

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

Provisions for Continued Participation

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

1. You fail to remit self-payments on time or in the proper amount.
2. You fail to remain a member in good-standing with your local union.
3. You become eligible for Medicare.

   It is your responsibility to provide the Fund Office with a copy of your Medicare card as soon as you obtain such card. You must obtain both Parts A and B of Medicare when you are eligible to purchase same.

Coverage may be continued for your eligible dependents under the Retiree Self-Payment Program. Refer to sub-section, "Retiree Self-Payment Program," for details.

4. Termination or modification of the Early Retiree Self-Payment Program.

You may continue coverage for your spouse and/or eligible dependent children under this program until one of the following events occurs:

1. You fail to remit self-payments on time or in the proper amount
2. You fail to remain a member in good-standing with your local union
3. You become eligible for Medicare
4. Your child or children no longer meet the definition of Dependent Child
5. The Early Retiree Self-Payment Program is terminated or modified
6. Your death
7. Your spouse becomes eligible for Medicare
8. Your spouse no longer meets the definition of Spouse.

Special Provisions – Early Retiree

1. If you decide to discontinue remitting self-payments or fail to remit your self-payments in a timely manner, coverage will terminate on the first day of the month following the month for which the final payment was made. Such termination of coverage is automatic and no notification is sent to you. And, you will not have an opportunity to participate in the Plan's Supplement to Medicare Program at the age of 65, even if you otherwise meet the qualifications of that program because coverage must be continuous.
2. Special consideration for reinstatement in the Early Retiree Self-Payment Program may be given to you by the Administrative Manager. You must make a written request for reinstatement.
3. You may elect to discontinue coverage for yourself and your dependents and reinstate your coverage at a later date. You must submit a letter to the Appeals Committee requesting the change prior to the date coverage is to be cancelled. In addition, upon reinstatement you must provide documentation that health care coverage was maintained for you and/or your dependents under another group health care plan.
4. You may choose not to cover your spouse. This election must be made in writing. If your spouse has coverage through their employer and subsequently

loses that coverage, you may begin to remit self-payments to provide your spouse with coverage upon submission of proof of the loss of group coverage. This proof must be submitted within 30 days following the loss of her coverage. Coverage for her may then begin the first day of the month following the month in which the Fund Office is notified.

5. If you are single and remitting self-payments and then marry, you may begin to cover your new spouse effective with the date of marriage. You must provide proof of your marriage to the Fund Office within 30 days from the date of such marriage along with the additional self-payment amount, if any. Current self-payment rates can be obtained from the Fund Office.
6. If you acquire dependent children, notification and proper documentation (marriage license, birth certificates, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within 30 days along with the additional self-payment amount, if any, for such coverage. The dependent children will be covered effective with the date as of which the definition of Dependent Child is met and any additional self-payment amount is paid, provided proper documentation of such status has been received by the Fund Office. Current self-payment rates can be obtained from the Fund Office.
7. If you return to work at the trade, you may continue to remit self-payments under this program until such time as you satisfy the eligibility provisions of the Active Program. Credit will be given for contributions remitted to the Fund that may not be sufficient to satisfy the eligibility provisions of the Plan. It is your responsibility to notify the Fund Office, in writing, if you return to work. It is also your responsibility to notify the Fund Office, in writing, when you again retire.

Totally and Permanently Disabled Participant Self-Payment Program

Covered Employees, who become totally and permanently disabled before the age of 65, are considered Totally and Permanently Disabled Participants with the Health Care Fund until they become eligible for Medicare benefits.

Eligibility Provisions

To continue coverage under the Health Care Fund as a Totally and Permanently Disabled Participant, you must be receiving monthly pension benefits from one of the following sources:

- The Michigan Carpenters' Pension Fund
- The Detroit Carpenters' Pension Fund
- The Social Security Administration.

If you are eligible for Medicare, your coverage will be provided under the Supplement to Medicare Program, provided you meet the qualifications for that program. If you fail to meet those qualifications, no coverage will be available through the Plan. Your dependent(s), provided they are not eligible for Medicare, may be covered through the Retiree Self-Payment Program. If your dependent(s) is/are also eligible for Medicare, coverage will be provided for such dependent(s) under the Supplement to Medicare Program, provided they meet the qualifications for that program. If they fail to meet those qualifications, no coverage will be available through the Plan.

You must be eligible either by employer contributions, self-contributions, or use of employer contributions on the date of retirement to be eligible to participate in the Totally and Permanently Disabled Participant Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the Active Program.

Schedule of Benefits for Totally and Permanently Disabled Participants

The schedule of benefits is the same for Totally and Permanently Disabled Participants and their dependents (who are not eligible for Medicare) as the schedule of benefits in effect for Active (Non Retired) Participants, with the exception of Burial Benefits and Prescription Coverage. No Accidental Death and Dismemberment Benefits are available for Totally and Permanently Disabled Participants and their spouses. Refer to Section 4 for an explanation of Retiree Burial Benefits.

Method of Payment for Coverage

Self-payments must be postmarked by the 20th day of the month preceding the month for which payment is being made. For example, the self-payment to provide coverage for the month of September must be postmarked by August 20th. Self-payments are to be made either by check or money order made payable to "Michigan Carpenters' Health Care Fund."

You may elect to have self-payments deducted from your Michigan Carpenters' Pension Fund monthly benefit check. The appropriate authorization form must be executed by the 20th day of the month preceding the month such deductions are to begin. The authorization forms are available from the Fund Office. Cancellation of the deductions must be made, in writing, at least 60 days before the effective date of cancellation.

Self-contributions may be made by credit card as well. Please contact the Fund Office for the appropriate forms.

You may remit self-payments for up to six (6) months in advance. Upon receipt of the self-payment, the Fund Office will send only one notification to you of the due date and amount of your next self-payment. It is your responsibility to remit

your next self-payment in a timely manner since no additional notification will be sent.

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

Provisions for Continued Participation – Totally and Permanently Disabled
You may continue your coverage under the Totally and Permanently Disabled Participant Self-Payment Program until one of the following events occurs:

1. You fail to remit self-payments on time or in the proper amount
2. You fail to remain a member in good-standing with your local union
3. You become eligible for Medicare
4. The Totally and Permanently Disabled Self-Payment Program is terminated or modified.

You may continue coverage for your spouse and/or eligible dependent children under this program until one of the following events occurs:

1. You fail to remit self-payments on time or in the proper amount
2. You fail to remain a member in good-standing with your local union
3. You become eligible for Medicare
4. Your child or children no longer meet the definition of Dependent Child
5. The Totally and Permanently Disabled Participant Self-Payment Program is terminated or modified
6. Your death
7. Your spouse becomes eligible for Medicare
8. Your spouse no longer meets the definition of Spouse.

Special Provisions – Totally and Permanently Disabled

If you decide to discontinue remitting self-payments or fail to remit your self-payments in a timely manner, coverage will terminate on the first day of the month following the month for which the final payment was made. Such termination of coverage is automatic and no notification is sent to you. You will not have an opportunity to participate in the Plan under the Supplement to Medicare Program when eligible for Medicare, even if you meet the qualifications of that program since coverage must be continuous.

1. Special consideration for reinstatement in the Totally and Permanently Disabled Participant Self-Payment Program may be given to you by the Administrative Manager to whom such authority has been delegated or by the Appeals Committee of the Board of Trustees. In either case, a written request for reinstatement must be made by you.
2. You may choose not to cover your spouse. This election must be made in writing. If your spouse has other coverage through their employer, and they subsequently lose that coverage, you may begin to remit self-payments to provide your spouse with coverage upon submission of proof of the loss of their group coverage. This proof must be submitted within 30 days following the loss of your spouse's coverage. Coverage for your spouse may then begin the first day of the month following the month in which the Fund Office is notified.
3. If you are single and remitting self-payments and then marry, you may begin to cover your new spouse effective with the date of marriage. You must provide proof of your marriage to the Fund Office within 30 days from the date of such marriage along with the additional self-payment amount, if any. The current self-payment rates can be obtained from the Fund Office.
4. If you acquire dependent children, notification and proper documentation (marriage license, birth certificates, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within 30 days along with the additional self-payment amount, if any, for such coverage. The dependent children will be covered effective with the date as of which the definition of Dependent Child is met and any additional self-payment amount is paid, provided proper documentation of such status has been received by the Fund Office. Current self-payment rates can be obtained from the Fund Office.
5. If you return to work, you may continue to remit self-payments under this program until such time as you satisfy the Plan's eligibility provisions of the Active Program. Credit may or may not be given for contributions remitted on your behalf that are not sufficient to satisfy the eligibility provisions of the Plan. It is your responsibility to notify the Fund Office, in writing, if you return to work so that a complete review of your status, as described in number 6 below, can be completed. It is also your responsibility to notify the Fund Office, in writing, when you again retire.
6. You are subject to review of your continued disability status at least once every two (2) years. You will be contacted by the Fund Office and required to submit the documentation to substantiate your continuing disability status. Such documentation will be reviewed by the Fund Medical Consultant and/or

the Administrative Manager's Office, with a final determination being made by the Appeals Committee of the Board of Trustees.

Retiree Self-Payment Program

This program provides coverage for the Eligible Dependents of Retired Participants who are covered under the Supplement to Medicare Program.

Eligibility Provisions

To continue coverage under the Health Care Fund as a Dependent of a Retired Participant, the Retired Participant must be receiving monthly pension benefits from one of the following sources:

- The Michigan Carpenters' Pension Fund
- The Detroit Carpenters' Pension Fund
- The Social Security Administration.

If you are a retiree but not receiving a monthly pension benefit from one of the three (3) sources listed above, you may still be eligible to participate in the program provided you have been continuously eligible via employer contributions for the three (3) years immediately preceding your retirement. Please contact the Fund Office for more information.

If you are eligible for Medicare, your coverage will be provided under the Supplement to Medicare Program, provided you meet the qualifications for that program. If you fail to meet those qualifications, no coverage will be available through the Plan. Your dependent(s), provided they are not eligible for Medicare, may be covered through the Retiree Self-Payment Program. If your dependent(s) is/are also eligible for Medicare, coverage will be provided for such dependent(s) under the Supplement to Medicare Program, provided the dependent(s) meet the qualifications for that program. If they fail to meet those qualifications, no coverage will be available through the Plan.

You must be eligible either by employer contributions, self-contributions, or use of employer contributions on the date of your retirement for your dependents to participate in the Retiree Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the Active Program or one of the Retired Participant Self-Payment Programs.

Schedule of Benefits for Dependents of Retired Participants

This schedule of benefits is the same for Dependents of Retired Participants as the schedule of benefits in effect for Active (Non-Retired) Participants, with the

exception of Burial Benefits and Prescription Coverage. No Accidental Death and Dismemberment Benefits are available for Retired Participants and their spouses.

Method of Payment for Coverage

Your self-payments must be postmarked by the 20th day of the month preceding the month for which payment is being made. For example, the self-payment to provide coverage for the month of September must be postmarked no later than August 20th. Self-payments are to be made by either check or money order made payable to "Michigan Carpenters' Health Care Fund."

You may elect to have self-payments deducted from your Michigan Carpenters' Pension Fund monthly benefit check. The appropriate authorization form must be executed by the 20th day of the month preceding the month such deductions are to begin. The authorization forms are available from the Fund Office. Cancellation of the deductions must be made, in writing, at least 60 days before the effective date of cancellation.

Self-contributions may be made by credit card as well. Please contact the Fund Office for the appropriate forms.

You may remit self-payments for up to six (6) months in advance. Upon receipt of the self-payment, the Fund Office will send only one notification to you of the due date and amount of your next self-payment. It is your responsibility to remit your next self-payment in a timely manner since no additional notification will be sent.

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

Provisions for Continued Participation

You may continue coverage for Dependents only under the Retiree Self-Payment Program. Coverage for the Retired Participant who is eligible for Medicare is provided under the Supplement to Medicare Program, if you meet the eligibility provisions for that program.

You may continue coverage for your spouse and/or eligible dependent children under this program until one of the following events occurs:

1. You fail to remit self-payments on time or in the proper amount
2. You fail to remain a member in good-standing with your local union
3. Your child or children no longer meet the definition of Dependent Child
4. The Retiree Self-Payment Program is terminated or modified
5. Your death

6. Your spouse becomes eligible for Medicare
7. Your spouse no longer meets the definition of Spouse.

Special Provisions – Retiree Self-Payment Program

1. If you decide to discontinue remitting self-payments or fail to remit your self-payments in a timely manner, coverage will terminate on the first day of the month following the month for which the final payment was made. Such termination of coverage is automatic and no notification is sent to you.
2. Special consideration for reinstatement in the Retiree Self-Payment Program may be given to you by the Administrative Manager to whom such authority has been delegated or by the Appeals Committee of the Board of Trustees. In either case, a written request for reinstatement must be made by you.
3. You may choose not to cover your spouse. This election must be made in writing. If your spouse has other coverage through their employer, and your spouse subsequently loses that coverage, you may begin to remit self-payments to provide your spouse with coverage upon submission of proof of the loss of your spouse's group coverage. This proof must be submitted within 30 days following the loss of your spouse's coverage. Coverage for your spouse may then begin the first day of the month following the month in which the Fund Office is notified.
4. If you are single and remitting self-payments and then marry, you may begin to cover your new spouse effective with the date of marriage. You must provide proof of your marriage to the Fund Office within 30 days from the date of such marriage along with the additional self-payment amount, if any. Current self-payment rates can be obtained from the Fund Office.
5. If you acquire dependent children, notification and proper documentation (marriage license, birth certificates, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within 30 days along with the additional self-payment amount, if any, for such coverage. The dependent children will be covered effective with the date as of which the definition of Dependent Child is met, provided proper documentation of such status has been received by the Fund Office. Current self-payment rates can be obtained from the Fund Office.
6. If you return to work at the trade, you may continue to remit self-payments under this program until such time as you satisfy the eligibility provisions of the Active Program. No credit will be given for employer contributions remitted on your behalf that are not sufficient to satisfy the eligibility provisions of the Plan. It is your responsibility to notify the Fund Office in writing, if you return

to work. It is also your responsibility to notify the Fund Office in writing, when you again retire.

Surviving Spouse Self-Payment Program

Eligibility Provisions

The Surviving Spouse and/or Surviving Dependent Children of a deceased Employee or deceased Retired Participant may be eligible for continued coverage under the Plan provided both the deceased Employee and the Surviving Dependents were covered under the Fund on the date of the Employee's death. Coverage is also available under the COBRA Continuation Provisions. Refer to the sub-section, "COBRA Continuation Coverage," for information.

If the surviving spouse is not yet eligible for Medicare, she may make self-payments for continued coverage under the Fund for herself and/or surviving Dependent Children. The amount of self-payment is established by the Trustees and may be changed from time to time. Currently, a lower self-payment rate is established for the first six (6) months for which payments are required.

If the surviving spouse is eligible for Medicare at the time she qualifies to make self-payments under this provision, she may make monthly self-payments for herself under the Supplement to Medicare Program at the applicable self-payment rate. If there are also surviving Dependent Children, an additional self-payment will be required to provide such children with continued coverage under another portion of the Plan.

Self-payments are not required from a Surviving Spouse and/or Surviving Dependent Children until the first day of the month after the banked contributions of a Deceased Active Employee are no longer enough to "pay" for coverage.

Schedule of Benefits for Dependents of Deceased Participants

The schedule of benefits is the same for Dependents of Deceased Participants as the schedule of benefits in effect for Active (Non -Retired) Participants, with the exception of Burial Benefits. No Accidental Death and Dismemberment Benefits are available for Retired Participants and their spouses.

Method of Payment for Coverage – Dependents of Deceased Participants

Self-payments from a Surviving Spouse under this program must be postmarked by the 20th day of the month for which such self-payment is being made. For example, the self-payment to provide coverage for the month of September must be postmarked by August 20th. Self-payments will only be accepted in the form of a check or money order made payable to "Michigan Carpenters' Health Care

Fund." Self-payments may be mailed or delivered to the Fund Office, and must be received on or before the established due date. If the Surviving Spouse is receiving monthly benefits from the Michigan Carpenters' Pension Fund, she may authorize a deduction of her self-payment from her monthly benefit check.

Self-contributions may be made by credit card as well. Please contact the Fund Office for the appropriate forms.

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

Termination of Coverage – Dependents of Deceased Participants

Coverage for the Surviving Spouse will terminate on the first day of the month following one of these events:

1. Remarriage of the Surviving Spouse
2. The failure to remit a self-payment in the correct amount by the specified due date
3. The Surviving Spouse Self-Payment Program is terminated or modified.

Coverage for Dependent Children will terminate on the first day of the month following one of these events:

1. The Surviving Spouse Self-Payment Program is terminated or modified
2. The failure to remit a self-payment in the correct amount by the specified due date
3. The failure to meet the definition of Dependent Child as defined in the Plan.

Special Provisions – Dependents of Deceased Participants

1. Once coverage is elected under this program, continuous coverage must be maintained through self-payments. If coverage is terminated for any reason, the Surviving Spouse and/or Surviving Children will not be permitted to make self-payments at any future time.
2. This coverage is subject to the Coordination of Benefits provision in that no duplication of benefits will be paid by the Fund if the Surviving Spouse and/or Surviving Dependent Children are eligible for benefits under any other insurance program or Medicare.
3. No Burial Benefits or Accidental Death and Dismemberment Benefits are provided for persons covered by this program.
4. Persons eligible for Medicare will have coverage provided under the Supplement to Medicare Program.

5. Those not eligible for Medicare will have the same health benefits as the Active Employees, except Burial Benefits, and Accidental Death and Dismemberment Benefits.
6. All provisions, limitations, qualifications, exclusions, etc., as described in this booklet, will apply to persons covered under this program.

Supplement to Medicare Program

Eligibility Provisions

Supplement to Medicare coverage is available to you and/or your spouse who is eligible for Medicare. This coverage is also available to Totally and Permanently Disabled Participants and/or spouses who are eligible for Medicare. Coverage is provided through self-payments under the Supplement to Medicare Program. To participate in this program, the Retired Participant must meet the following eligibility requirements:

1. You must have been eligible as an Active Participant in at least five (5) of the ten (10) years immediately preceding the date of retirement.
2. You must be receiving monthly benefits from either:
   - Michigan Carpenters' Pension Fund
   - Detroit Carpenters' Pension Fund
   - Social Security Administration

   Retirees not receiving a monthly pension benefit from one of the three (3) sources listed above may be eligible to participate in the program provided they have been continuously eligible via employer contributions for the three (3) years immediately preceding their retirement. Please contact the Fund Office for more information.
3. You must have both Parts A (Hospital) and B (Medical) coverage under Medicare. A copy of the Retiree and/or Spouse's Medicare card must be submitted.
4. You must be a member in good standing with your local union. Your status will be checked when you are added to the Program and will be checked once each year thereafter.
5. Coverage based upon employer contributions or banked contributions has terminated.
6. You and/or your spouse is eligible to be added on the first day of the month your spouse becomes eligible for both Parts A and B of Medicare

7. Participation in this program must begin within one (1) year from the date you or your spouse is eligible to participate.
8. Your spouse is eligible to be added to this program only if you meet provision numbers 1, 2, 4, 5 and 7 as described above. In addition, you must be maintaining coverage for yourself under one of the Retired Participant Self-Payment Programs. Your spouse must have both Parts A and B of Medicare.
9. You and/or your spouse are required to obtain both Part A and B when either of you are eligible for such coverage through Medicare.

Method of Payment for Coverage – Supplement to Medicare

Self-payments must be postmarked by the 20th day of the month preceding the month for which payment is being made. For example, the self-payment to provide coverage for the month of September must be postmarked by August 20th. Self-payments are to be made by either check or money order made payable to "Michigan Carpenters' Health Care Fund."

Self-contributions may be made by credit card as well. Please contact the Fund Office for the appropriate forms.

You may elect to have self-payments deducted from your Michigan Carpenters' Pension Fund monthly benefit check. The appropriate authorization form must be executed by the 20th day of the month preceding the month such deductions are to begin. Authorization forms are available from the Fund Office. Cancellation of the deductions must be made, in writing, at least 60 days before the effective date of cancellation.

You may remit self-payment for up to six (6) months in advance. Upon receipt of the self-payment, the Fund Office will send only one notification to you of the due date and amount of your next self-payment. It is your responsibility to remit your next self-payment in a timely manner since no additional notification will be sent.

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

Provisions for Continued Participation – Supplement to Medicare

You may continue your coverage under the Supplement to Medicare Program until one of the following events occurs:

1. You fail to remit self-payments on time or in the proper amount
2. You fail to remain a member in good-standing with your local union

3. Coverage may be continued for eligible dependents under the Retiree Self-Payment Program
4. The Supplement to Medicare Program is terminated or modified
5. Your death
6. You lose your Medicare coverage.

You may continue coverage for your spouse and/or eligible dependent children under this program until one of the following events occurs:

1. You fail to remit self-payments on time or in the proper amount
2. You fail to remain a member in good-standing with your local union
3. Dependent no longer qualifies for Medicare
4. Your child or children no longer meet the definition of Dependent Child
5. The Retired Participant Self-Payment Program is terminated or modified
6. Your death
7. Your spouse no longer meets the definition of Spouse.

Special Provisions – Supplement to Medicare

1. If you decide to discontinue remitting self-payments or fail to remit your self-payments in a timely manner, coverage will terminate on the first day of the month following the month for which the final payment was made. Such termination of coverage is automatic and no notification is sent to you.
2. Special consideration for re-instatement in the Supplement to Medicare Program may be given to you by the Administrative Manager to whom such authority has been delegated or by the Appeals Committee of the Board of Trustees. In either case, a written request for re-instatement must be made by you.
3. You may choose not to cover your spouse if your spouse has other health care coverage. This election must be made in writing. If your spouse has other coverage through their employer, and your spouse subsequently loses that coverage you may begin to remit self-payments to provide your spouse with coverage upon submission of proof of the loss of your spouse's group coverage. This proof must be submitted within 30 days following the loss of your spouse's coverage. Coverage for your spouse may then begin the first day of the month following the month in which the Fund Office is notified, provided proper self-payment is remitted.

4. If you are single and remitting self-payments and then marry, you may begin to cover your new spouse effective with the date of marriage. You must provide proof of your marriage to the Fund Office within 30 days from the date of such marriage along with the additional self-payment amount, if any. Current self-payment rates can be obtained from the Fund Office.
5. If you acquire dependent children, notification and proper documentation (marriage license, birth certificates, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within 30 days along with the additional self-payment amount, if any, for such coverage. The dependent children will be covered effective with the date as of which the definition of Dependent Child is met and any additional self-payment amount is paid, provided proper documentation of such status has been received by the Fund Office. Current self-payment rates can be obtained from the Fund Office.
6. If you return to work at the trade, you may continue to remit self-payments under this program until such time as you satisfy the eligibility provisions of the Active Program. No credit will be given for contributions remitted on your behalf that are not sufficient to satisfy the eligibility provisions of the Plan. It is your responsibility to notify the Fund Office in writing, if you return to work. It is also your responsibility to notify the Fund Office in writing, when you again retire.

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About Your Blue Cross Blue Shield Benefits

This section is designed to help you understand your current Blue Cross Blue Shield of Michigan (BCBSM) benefits. It is intended to be a **general summary** of your coverage.

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

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

2. To obtain a copy of your certificates and riders, refer to the instructions on the back of Part II of this booklet.

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

Please discard any prior descriptions of your benefits.

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Section 2. How to Reach BCBSM

Customer Service Information

If you need to call or write BCBSM about a claim or your coverage, it's important to give BCBSM the contract number that's printed on your BCBSM ID card. **You'll receive the quickest service possible if you contact your dedicated Customer Service Center.**

Use the phone number that's printed on the back of your ID card, or refer to the number below. Customer service hours are Monday through Friday from 8:30 a.m. to 5 p.m.

To Call	To Write BCBSM
1-800-570-1144	Major Accounts Service Center, **Mail Code X420** **Blue Cross Blue Shield of Michigan** 600 E. Lafayette Blvd. Detroit, MI 48226-2998

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

Hearing and Speech Impaired Customers

Area codes 248, 313 586, 734, 810 and 947 .....(313)225-6903

Area codes 231, 269, and 616.. (616) 285-2114 or 1-800-570-1144

Special Servicing Numbers

Anti-Fraud Hotline..... 1-800-482-3787
Blue HealthLine[SM] 1-800-811-1764
Hearing-impaired customers..... 1-800-240-3050
BlueSafe[SM] Hotline 1-877-BLUESAFE (258-3723)
Human Organ Transplant Program 1-800-845-5982
Individual Case Management Program..... 1-800-845-5982
Senior Help Line 1-888-327-9148
Naturally Blue Program..... 1-888-718-7011

Web site Addresses

BCBSM Home Page .....www.bcbsm.com
Anti-Fraud.....www.bcbsm.com/antifraud/contact.shtml

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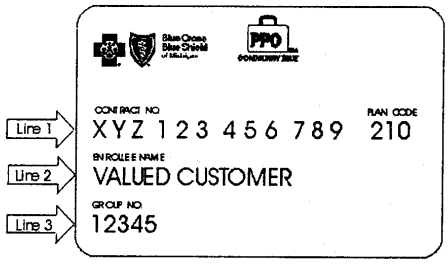
Section 3. General Information

Your Identification Card

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



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

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

Plan Code identifies you as a Michigan Blue Cross Blue Shield of Michigan member.

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

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

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

Here are some tips about your ID card:

- Sign the signature strip immediately to help prevent fraudulent use.
- Carry your card with you at all times to help avoid delays when you need medical attention.

- If you, or anyone in your family, need a card, please call the Fund Office.

- Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

- Call your Fund Office if your card is lost or stolen. You can still receive services by giving the provider your contract number to verify your coverage.

Customer Service

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

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

- Have your contract number ready

If you are questioning a service, please provide:

- Patient and provider's name
- Date the patient was treated
- Type of service, such as an office visit
- Charge for each service

When corresponding with BCBSM, please make sure your contract number is on each page and you should keep a copy for your records.

When visiting BCBSM customer service offices, please bring a copy of any bills, forms or other materials related to your inquiry.

Preventing Fraud

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

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

If you suspect health care fraud against BCBSM, let us know.

If your health care coverage is through BCBSM, call the BCBSM Anti-Fraud Hotline at **1-800-481-3787**. Your call is strictly confidential.

Write BCBSM at the following address:

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

- Contact BCBSM online at www.bcbsm.com/antifraud/contact.shtml

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Section 4. Eligibility

Dependent Coverage

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

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

Eligible children include:

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

Dependent Continuation Coverage

Dependents whose ages are 19 through 25 may continue coverage under your contract if they meet **all** the following requirements:

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

You must apply for Continuation Coverage before the end of the year in which the dependent turns 19. This coverage continues until the end of the year in which they turn 25, if they remain eligible. Coverage for these dependents will be exactly the same as yours. You are responsible for paying the cost of coverage for these dependents.

Important: *If you have a dependent who is no longer eligible for health coverage on your contract, BCBSM has many benefit options available to continue his or her coverage. Call the customer service number in Section 1 for more information.*

To Add a Dependent to Your Contract

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

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

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

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

To Remove a Dependent from Your contract

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

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

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

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

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

To Change Your Address

If you change your address, or if your address is incorrect in the BCBSM records, please notify your Fund Office and fill out an *Enrollment/change of Status* form promptly. This will ensure that you will continue to receive any notices BCBSM

sends to you. Remember to include your group and contract number whenever you contact BCBSM or the Fund Office.

Continuing Coverage on Your Own

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

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

2. Convert to individual coverage, called **Group Conversion** through BCBSM.

An explanation of both options has been provided; however you will need to contact the Fund Office to clarify eligibility dates and to select type of coverage best for you.

COBRA Continuation Coverage

COBRA coverage is available for all Fund members. It applies to you, your spouse, and any children including children born or adopted after you become eligible for COBRA if they are enrolled timely. The person who lost the group coverage is called a "qualified beneficiary."

The Fund Office will notify you and your dependents when you become eligible for COBRA benefits. In the case of your death, the fund Office must notify your dependents about their eligibility. To continue coverage, you must notify the Fund Office within 60 days after you have received your notice of your right to continue coverage. In cases of divorce, you or your former spouse must notify the Fund Office within 60 days in order to be eligible for this coverage. You or your dependents will then be responsible for paying a premium plus a small administrative fee.

Member continuation coverage – If you lose your coverage because of layoff, reduction in your hours of employment or termination from the Fund (for other than gross misconduct), coverage is available to you and your dependents for up to 18 months. You are responsible for paying the cost of coverage.

Continuation coverage is available for up to 29 months if:

- You or any qualified beneficiary has been determined to be disabled by the Social Security Administration at the time coverage is terminated, **or**

- You or any qualified beneficiary are determined to be disabled by the Social Security Administration any time during the first 60 days of COBRA coverage.

Dependent continuation coverage – Your dependents have the right to continue their coverage for up to 36 months when they are no longer eligible under your plan because:

- Your plan under which they were covered is canceled due to your death.

- You become entitled to Medicare, and your spouse or dependents lose group coverage as a result.

- Divorce or legal separation causes a spouse to lose coverage.

- Children no longer meet dependent eligibility requirements under your plan.

Level of coverage – If you or your dependents choose COBRA Continuation Coverage through the Fund, you will be offered the same level of benefits that active employees have. You may continue the COBRA coverage you select until the earliest of the following situations:

- The end of the continuation period that applies to you.

- The date the Fund no longer provides coverage to any of its employees.

- The date you do not make payment for COBRA coverage.

- The date you or your dependents become covered under another group health care plan *(unless that plan includes exclusions or limitations about pre-existing conditions that apply to you or your dependents).*

- The date you or your dependents become entitled to Medicare.

Blue Cross Blue Shield Group Conversion Coverage

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

- As an alternative to COBRA when you first become eligible for COBRA **or**
- At the end of your COBRA eligibility period **if** you made all required payments during that period.
- Your benefits may change under Group Conversion coverage, and the coverage will be limited to your immediate family, but there will be no interruption of coverage provided you pay the initial and subsequent bills. You must be a Michigan resident for at least six months out of each year to be eligible for this type of coverage.
- To ensure continuous coverage, you must submit a written request for Group Conversion coverage to BCBSM within 30 days from the date you are no longer eligible for group coverage through the Fund **or** within six months before the COBRA coverage ends. For additional information on how to apply for this coverage, contact the Fund Office or call the BCBSM customer service number in Section 2.

Certificate of Creditable Coverage

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

Section 5. Choosing a Network Provider

What You Need to Know

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

- Network providers
- Non-network provides
- BlueCard PPO program
- Care out of the country

Community Blue[SM] PPO is designed to provide you with the highest level of benefits and the lowest out-of-pocket costs when you choose PPO network providers. You also have the freedom to receive care from a non-network provider, but with higher out-of-pocket costs.

Network Providers

Community Blue PPO uses a network of physicians, hospitals, and other health care specialist who have signed agreements with BCBSM to accept the BCBSM approved amount as payment in full for covered services. When you use a PPO network provider, your out-of-pocket costs for covered services are limited to the **copayments** listed in Section 6.

Here is what you need to do when you need medical care:

- Choose a provider by logging onto the BCBSM Web site at **www.bcbsm.com/directories,** and

Make your appointment directly with that provider.

With community Blue PPO, you do not have to choose just one provider for your care and you do not have to notify BCBSM if you decide to change physicians. Just remember to select a PPO provider and you will stay in-network. If you would like to verify if a provider is in the BCBSM PPO network, please call the customer service number in Section 2.

To receive benefits at the in-network level, your care must be received from a PPO provider. You do not need to use a PPO provider for the following services; however, you must follow any coverage requirements outlined in this booklet:

- Services for which a PPO network has not yet been established (see Section 6)
- Services covered under a separate prescription drug, dental, vision, or hearing plan

Special Note for Parents of Students: *If you have dependents attending school in Michigan, but living away from home, you should help them choose a PPO physician near their school. Remember to access the BCBSM Web site for PPO providers.*

Change in Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or other wise cease to be affiliated with the BCBSM PPO network. Should this happen, your physician should notify you that he or she is no longer in the PPO network. You should try to find another PPO physician. If you wish to continue care with your current physician, a customer service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Non-Network Providers

When you receive care from a provider who is not part of the PPO network, without a referral form from a PPO network provider, your care is considered out-of-network. Before choosing a non-network provider, you should verify if the service would be covered. Some services such as preventive care services **are not covered out-of-network**.

If you choose to receive services from a non-PPO provider, you can still limit your out-of-pocket costs if the provider participates in the BCBSM **Traditional** program.

If you use a Blue **Traditional** participating provider who does not participate in the BCBSM PPO network:

- The provider will bill BCBSM directly for your services, **and**

- You are responsible for your out-of-network deductible and copayments unless you have a referral from your PPO physician. However, you will not be billed for any differences between the BCBSM approved amount and the provider's charge.

BCBSM coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency. There is no coverage for non-emergency hospital services performed by a nonparticipating hospital.

- Payment for emergency services received from a Michigan nonparticipating hospital is limited to $70 per day for inpatient services in accredited general acute care facilities, $15 per day in accredited specialty hospitals, and $25 per condition for outpatient emergency services.

- Blue Cross Blue Shield will pay the BCBSM approved amount for emergency services provided by an accredited nonparticipating hospital outside of Michigan if the hospital participates with another Blue Cross Blue Shield Plan **or** is located in an area not served by another Blue Cross Blue Shield Plan.

Be sure to find out your provider's participation status before you receive services. If your physician does not participate with BCBSM, ask if he or she will participate on a "per claim" basis.

Note: BCBSM does not cover services received at nonparticipating outpatient physical therapy facilities, mental health or substance abuse treatment facilities, freestanding ambulatory surgery facilities, home health care agencies, hospice programs or skilled nursing facilities.

If you use a provider who **does not participate** with BCBSM's PPO network or Traditional program, you may be responsible for any difference between the provider's charge and the BCBSM approved amount and may need to file your own claims. When you use these nonparticipating providers, BCBSM will send you the approved amount, less out-of-network deductible and copayments. You are responsible for paying the provider and any balances remaining that may exceed the approved amount.

BlueCard PPO Program

With the BlueCard program, you can locate doctors and hospitals quickly and easily. When you need medical care **outside Michigan,** you can receive in-network benefits by using the BlueCard PPO program.

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

1. Call **1-800-810-BLUE (2583)** for the names and addresses of doctors and hospitals in the area where you need care.

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

2. When you arrive at the doctor's office or hospital, show your BCBSM ID card. Remind the provider you are covered under the BlueCard program and to **include the XYP alpha prefix** on all claims

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

BlueCard PPO providers will bill their local Blue Plan for covered services you received. The local Blue Plan will not reduce its payment to BlueCard PPO providers by the out-of-network deductible and/or copayments. You are responsible only for the in-network deductible (*if any*) and copayments listed in Section 5 and for services not covered by your plan.

You will not be expected to pay any out-of-network copayments or deductibles if:

- You receive treatment for an accidental injury or a medical emergency, or
- You are referred to a non-network provider by a BlueCard participating PPO provider.

Note: If you are referred to a **nonparticipating provider** (see Glossary for definition of a nonparticipating provider) you may be billed for the difference between the provider's charge and the BCBSM approved amount. However, if you are charged out-of-network deductible and/or copayments, please call the customer service number in Section 2.

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

Care Out of the Country

Your coverage applies no matter where you are only if:

- The hospital is accredited
- The physician is licensed

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

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Section 6. How Your Community Blue PPO Plan Works

Community Blue PPO gives you the choice of receiving care from a PPO network physician or outside the network from any physician. The choice is always yours.

When a PPO physician provides or refers your hospital and medical services, it is called "*In-Network*."

When a PPO physician does **not** provide or refer your services, it is called "*Out-of-Network."*

Each person enrolled in a Community Blue PPO plan is entitled to a lifetime benefit maximum of $5 million. Within this maximum, outpatient substance abuse treatment is covered up to the state-dollar annual amount.

Here's a diagram that shows how Community Blue PPO works. Please note that some services may not require in-network deductibles or copayments. Please refer to Section 5 and Section 6 for your plan's cost sharing requirements.

When you use any PPO Physician	When you choose a non-PPO physician who is	
	A Blue participating provider	A nonparticipating provider
Your plan may require: • An in-network deductible (if any) • An in-network percent copayment for most covered services • A fixed dollar copayment for selected office services and hospital emergency room services • A percent copayment for mental health care substance abuse treatment and private duty nursing You have: • No balance billings* • No claims form to fill*	You pay: • An out-of-network deductible • An out-of-network percent copayment for most covered services • A fixed dollar copayment for hospital emergency room services • A percent copayment for mental health care, substance abuse treatment and private duty nursing You have: • No balance billings* • No claims form to fill*	You pay: • An out-of-network deductible • An out-of-network percent copayment for most covered services • A fixed dollar copayment for hospital emergency room services • A percent copayment for mental health care, substance abuse treatment and private duty nursing You have: • Balance billings* • Claim forms to complete
You're in-network	**You're out-of-network**	**You're out-of-network**

*If you receive care from a nonparticipating provider, even when referred by a PPO network or Blue participating provider, you may be billed for the difference between the provider's charge and the BCBSM approved amount, and you may have to file your own claims.

In-Network Guidelines

To receive benefits at the in-network level, a PPO provider must provide or refer your care. The following lists those exceptions where BCBSM will pay services at the in-network level if they are received from a non-network provider.

- **Referrals** – Referral care services are services received from a provider not part of the PPO network **but coordinated by your PPO network physician**.

  - **Important**: A referral from your PPO provider does not guarantee payment. To be covered, the service must be a covered benefit and you must have a **written referral** from your PPO physician. You may be required to pay amounts above the BCBSM approved amount if the provider you are referred to does not participate with BCBSM's PPO network or Traditional program.

  - **Emergency Care** – When you think emergency care is needed, go the nearest medical facility. The initial exam to treat a life-threatening medical emergency or accidental injury is covered at the in-network level when the diagnosis meets medical emergency guidelines.

  Note: Follow-up care is not considered emergency care.

  - **PPO Network Exceptions** – The following types of services are covered at the in-network level of benefits when performed by a BCBSM participating provider:

    - Home health care through an approved agency
    - Freestanding substance abuse treatment programs
    - Hospice programs
    - Ambulance companies

- Durable medical equipment suppliers
- Prosthetic and orthotic suppliers
- Freestanding outpatient physical therapy facilities
- Ambulatory surgery facilities
- Skilled nursing facilities
- Certified nurse midwives
- Certified nurse practitioners

- Certified registered nurse anesthetists
- Freestanding outpatient psychiatric facilities
- Independent licensed physical therapists
- Outpatient mental health care facilities

Your In-Network Deductible

When you receive services in-network you must pay an in-network deductible of **$250** per individual of **$500** per family before payment will be made for benefits. This deductible is required each calendar year.

Reminder: When one individual has met the in-network deductible, benefits are payable for that individual. In-network services for the remaining family members will be paid when the full family deductible has been met.

The in-network deductible does <u>not</u> apply to:

- Preventive care services
- Covered services received in a PPO network physician's office
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office

- Services subject to a fixed dollar copayment
- Chiropractic spinal manipulation
- Pre-natal and post-natal care visits
- Allergy testing and therapy
- Injections
- Hospice care benefits

Your In-Network Copayments

You are required to pay the following **fixed dollar** copayments, which do not apply toward your copayment maximum:

- $10 copayment for office visits which includes urgent care visits and office consultations

Note: *There is no copayment for hospital emergency room treatment whether received in-network or out-of-network.*

You are required to pay the following **percent** copayments:

- 20 percent of the approved amount for most covered services
- 50 percent of the approved amount for private duty nursing

Note: Some services are covered at 100 percent of the approved amount, with no copayment, as indicated in Sections 6 and 7.

In-Network Copayment Maximum

After you have paid **$500** per individual or **$1,000** per family in in-network copayments, you do not need to pay any further **in-network copayments** for the rest of that year. However, you are still required to pay fixed dollar copayments and percent copayments for private duty nursing and any remaining out-of-network copayments.

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

- Deductibles, in-network or out-of-network
- Fixed dollar copayments
- Private duty nursing copayments
- Charges for non-covered services
- Charges in excess of the BCBSM approved amount

Out-of-Network Guidelines

When you receive services from providers who are not in the PPO network (out-of-network), you will be responsible for paying out-of-network deductibles and copayments, unless you have a referral from a PPO provider. **Preventive care services are not covered out-of-network.**

Your Out-of-Network Deductible

Your coverage requires you to pay a **$250** per individual or **$500** per family deductible before payment will be made for out-of-network benefits. This deductible is required each calendar year.

When one individual has met the out-of-network deductible, benefits are payable for that individual. Out-of-network services for the remaining family members will be paid when the full family deductible has been met.

The out-of-network deductible **does not** apply to:

- The initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Referrals to a non-network provider by a PPO network provider
- Home health care agencies
- Freestanding substance abuse treatment programs
- Ambulance providers

- Durable medical equipment providers
- Prosthetic and orthotic suppliers
- Freestanding physical therapy facilities
- Ambulatory surgery facilities
- Skilled nursing facilities
- Private duty nursing
- Hospice care

Your Out-of-Network Percent Copayments

After you have met your out-of-network deductible, you are required to pay the following copayments:

- **30** percent of the approved amount for most covered services
- **50** percent of the approved amount for private duty nursing

Out-of-Network Copayment Maximum

After you have paid **$1,000** per member or **$2,000** per family in out-of-network copayments for general services, you do not need to pay any further out-of-network copayments for the rest of that year. However, you are still required to pay fixed dollar copayments and percent copayments for private duty nursing.

Note: Out-of-network copayments also apply toward the in-network copayment maximum.

The following **cannot** be used to meet your out-of-pocket network copayment maximum:

- Deductibles, in-network or out-of-network
- Fixed dollar copayments
- In-network percent copayments
- Private duty nursing copayments
- Charges for non-covered services
- Charges in excess of the BCBSM approved amount

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Section 7. Community Blue PPO Hospital Coverage

This section explains your Community Blue PPO hospital benefits. Please check each section of this booklet carefully for a complete explanation of your benefits.

Important: Unless otherwise indicated, all services described in this section are subject to both in-network and out-of-network deductibles and copayments listed in Section 6.

Medical Necessity

A service must be medically necessary in order to be payable by your health care coverage. Medical necessity for the payment of **hospital services** requires that **all** of the following conditions be met:

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

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

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

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

Service Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this booklet, BCBSM will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends.

If your coverage begins or ends while you are an inpatient at a facility, the BCBSM payment will be based on the facility's contract with BCBSM. The BCBSM payment may cover:

- The services, treatment, care or supplies you receive during the entire admission, **or**

- The services, treatment, care or supplies you receive while your coverage is in effect.

In addition, if you have other coverage when you are admitted to or discharged from a facility, your other carrier may be responsible for paying for the care you receive before the effective date of your BCBSM coverage or after it ends.

Pain Management

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

Payment of Benefits

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

Hospital Benefits Inpatient

Room and Board

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

General Medical Care Days

You have an **unlimited number of inpatient days** for the diagnosis and treatment of general medical conditions. The following types of admissions are also considered general medical care:

- **Maternity and nursery care** – includes delivery room costs and routine nursery care for a newborn during an eligible mother's hospital stay. After the hospital stay, the newborn is covered as a dependent child. **You must notify the Fund Office to add the child to your coverage within 30 days of birth.**

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

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

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

Inpatient Mental Health Care and Substance Abuse Treatment Days

Your coverage provides benefits for inpatient mental health and inpatient substance abuse services. A mental health or substance abuse treatment admission can include individual and group therapy sessions and family counseling when provided through an approved facility.

Inpatient mental health care and inpatient and residential substance abuse treatment are payable for up to 60 days per calendar year with a lifetime maximum of 120 days.

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

- Individual psychotherapeutic treatments

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

- Group psychotherapeutic treatment.

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

Important: *Inpatient mental health care and substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. Your physician* ***must*** *call the BCBSM Mental Health Precertification Unit at* ***1-800-762-2382*** *for guidance.*

Hospital Services and Supplies

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

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

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

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

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

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

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

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

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

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

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

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

Hospital Benefits Outpatient

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

Emergency Medical Care in the Emergency Room

Your benefits include the initial exam and treatment of accidental injuries or conditions determined by BCBSM to be medical emergencies.

The following are not considered emergency care:

- Routine care for minor medical problems such as headaches, colds, slight fever and back pain
- Follow-up care

Note: *The exam, diagnosis, and treatment of illness or injury by a physician is payable when you are seen in the physician's office or in a* ***non-hospital*** *urgent care center.*

Pre-Admission Testing

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

Outpatient Physical, Occupational and Speech Therapy

Benefits are payable when provided in:

- The outpatient department of PPO network and participating hospitals
- Outpatient participating physical therapy facilities

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

Speech and language pathology services are payable for the treatment of congenital or inherited speech abnormalities, regardless of age.

Physical, occupational, and speech therapy services provided for rehabilitation are payable up to a **combined** maximum of 60 visits per member per calendar year. The 60-visit maximum renews each calendar year and is a **combined** in-network and out-of-network benefit maximum for all outpatient locations (hospital-based, freestanding facility or physician's office).

Your therapy **must:**

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

Examples of covered therapy are:

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

Your coverage **does not** pay for:

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

Outpatient Substance Abuse Treatment

Treatment is covered in approved residential and outpatient substance abuse treatment programs. The following criteria for the program must be met:

- You must have plan benefits available when you enter the program.
- Your physician must assign a diagnosis of substance abuse and must certify whether the treatment required is residential or outpatient.
- Your physician must:
  - Provide an initial physical examination
  - Provide and supervise your care during detoxification, and
  - Provide follow-up care during rehabilitation.
- The services must be medically necessary for treatment of your condition.
- The services must be approved by BCBSM and provided by a participating substance abuse treatment program.

Reminder: These services are subject to a percent copayment as well as the annual dollar amount designated by state law. *Since the state mandated substance abuse amount is adjusted annually, you should call the customer service number in Section 2 for the current benefit amount.*

Outpatient Mental Health Care

Services are payable in **participating** outpatient mental health care facilities. Benefits are payable for up to **50** visits per calendar year per individual with a lifetime maximum of **120 visits** per individual.

Benefits include:

- Counseling services provided by a physician, a fully licensed psychologist, or by the facility's staff
- Family counseling for members of the patient's family
- Ancillary services for patients who are admitted and discharged on the same day of treatment
- Prescribed drugs given by the facility in connection with treatment.

- Psychological testing by a physician, fully licensed psychologist, or a limited licensed psychologist when prescribed and billed by a physician or fully licensed psychologist

Chemotherapy

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

Hemodialysis

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

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

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

Alternatives to Hospital Care

As an alternative to hospital care, your coverage provides the following benefits:

Home Hemophilia Program

Your benefits include all medications and medical supplies needed for in-home treatment for hemophilia, including syringes, needles and the antihemophilic factor. Your physician must prescribe all services and all services and supplies

must be billed by a participating hospital. Your benefits also include training the patient or a family member on how to inject the antihemophilic factor, when the training is provided through an approved facility.

Home Health Care

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

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

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

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

- Physical, speech, and occupational therapy (up to a combined maximum of 60 visits per individual per calendar year; this benefit maximum renews each calendar year)

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

Your coverage **does <u>not</u>** pay for:

- General housekeeping services

- Transportation to or from a hospital or other facility

- Elastic stockings, sheepskin or comfort items such as lotion, mouthwash, body powder, etc.

- Physician services

- Custodial or non-skilled care.

Skilled Nursing Care

Care in a skilled nursing facility is covered when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. In addition, BCBSM requires written confirmation of the need for skilled care from the patient's physician. Once prescribed, your coverage will provide benefits for the period necessary for the care and treatment of the patient, up to a maximum of 120 days per calendar year. All services must be provided at a participating skilled nursing facility (see **Glossary**).

Your coverage **does <u>not</u>** pay for:

- Custodial care
- Care for senility or mental retardation
- Care for substance abuse
- Care for long-term mental illness.

Individual Case Management Program (ICMP)

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

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

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

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

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

- The patient's condition no longer requires the extra benefits documented in the Alternative Benefit Plan.

- The total amount paid under the Alternative Benefit Plan exceeds the amount that would be payable under the patient's regular hospital coverage.

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

Hospice Care

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

You may apply for hospice care benefits after discussion with and referral by your attending physician. Your request must be in writing to the hospice agency **and all hospice services must be arranged through an approved hospice provider.**

Electing Hospice Benefits

Hospice benefits are divided into three election periods: two 90-day periods and one 30-day period. A patient must exhaust the two 90-day periods before electing the 30-day period. Election periods continue until the patient exhausts all three periods or cancels his or her hospice benefits.

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

Levels of Care

The hospice program provides four levels of care:

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

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

- **Inpatient respite care** that consists of short-term inpatient services to allow the home care provider short periods of relief. Such care must be provided in an approved facility on a non-routine or occasional basis and in increments of five days or less in any 30-day period.

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

Hospice Services

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

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

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

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

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

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

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

Important: *Hospice benefits are covered at 100 percent of the approved amount. There is a separate dollar maximum for services provided by a physician who is not part of the hospice team. Please call the customer service number in Section 2 for information about the current dollar maximum: You are not required to meet deductibles or make copayments.*

Human Organ Transplants

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

Organ and Tissue Transplants

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

- Cornea

- Kidney

- Skin

- Bone Marrow (described below)

Blue Cross Blue Shield of Michigan will pay covered services for donors if the donor does not have transplant benefits under any health care plan.

Bone Marrow Transplants

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

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

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

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

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

Only the following conditions are covered:

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

Payable benefits for bone marrow transplants include:

- High-dose chemotherapy and/or total body radiation
- Blood tests on immediate relatives for evaluation as donors (if tests are not covered by the potential donor's health plan)
- Harvesting the marrow and/or peripheral blood stem cells if the donor meets specific genetic marker requirements for **allogeneic** bone marrow transplants; harvesting and storing the marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year for **autologous** bone marrow transplants

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

- Infusion of colony stimulating growth factors

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

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

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

Your coverage **does <u>not</u>** pay for:

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

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

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

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

- Services that are not medically necessary.

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

Specified Oncology Clinical Trials

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

In order for services to be payable as eligible benefits:

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

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

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

- The patient must be an eligible Blue Cross Blue Shield of Michigan member with hospital/medical/surgical coverage.

Note: *If the above requirements are not met, you will be responsible for* ***all*** *charges. Human Organ Transplants are also covered when received at a designated cancer center.*

Covered Services

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

When **preapproved** by BCBSM, the following services are covered:

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

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

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

  - Infusion of colony stimulating growth factors.

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

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

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

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

- Autologous transplants

  - Infusion of colony stimulating growth factors.

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

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

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

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

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

- Up to a total of $5,000 for travel, meals, and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins on the date of

approval and ends 180 days after the transplant. Blue Cross Blue Shield of Michigan will pay the expenses of an adult patient and one companion (or two companions if the patient is under age 18). Within the $5,000, the following amounts apply to the **combined** expenses of the patient and eligible companion(s):

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

Your coverage **does <u>not</u>** pay for:

- Services performed at a center that is not a National Cancer Center (NCI)-designated center or an affiliate of a NCI-designated center.
- A hospital admission, a length of stay at a hospital, **or any service that has not been pre-approved.**
- Harvesting (including phereses) and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplantation within one year.
- Any other services related to any of the above exclusions.
- Items or services, such as investigational drugs, non-health care services and/or research management (such as administrative costs) that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company).
- Services rendered as part of a protocol that does not meet the February 19, 1993 ASCO statement for clinical trials.
- Items that are not considered directly related to travel, meals, and lodging expenses. They include, **but are not limited to,** dry cleaning-clothing/laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationery/stamps, household products, household utilities, including cell phone charges, maid, baby-sitter/day care services.

Specified Human Organ Transplants

Hospital care for specified human organ transplants performed during the transplant benefit period is covered at 100 percent of the approved amount only when the transplant is received at a **BCBSM designated transplant facility** (see **Glossary** for a definition of a designated facility),

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

Note: *Call the BCBSM Human Organ Transplant Program at* ***1-800-242-3504*** *to confirm a facility's participation status.*

When **preapproved** and directly related to the transplant BCBSM will pay for the following services. Benefits are limited to a $1 million lifetime maximum for each type of human organ transplant.

- Facility and professional services.

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

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

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

- Reasonable and necessary cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ. The total payment for all services combined for each transplant will not be more than the $1 million lifetime maximum.

Your specified transplant coverage does not cover:

- Non-covered services.

- Living donor transplants other than liver and lobar lung transplants.

- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin).

- Anti-rejection drugs that do not have Food and Drug Administration marketing approval.

- Transplant procedures and related services that are not preapproved.

- Transplant surgery that is not performed in a designated facility.

- Transportation, meals and lodging costs under circumstances other than those related to the initial **preapproved** transplant surgery.

- Any expenses incurred for transportation, meals and lodging after the initial transplant surgery and hospitalization.

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

- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage.
- Experimental transplant procedures.

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Section 7B: Physician Benefits

Your coverage provides the following benefits for physician care.

Important: *Unless otherwise indicated, all services described in this section are subject to both in-network and out-of-network deductibles and copayments listed in Section 6. Remember, some services listed in this section are not covered out-of-network.*

Medical Necessity

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

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

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

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

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

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

Preventive Services

The following preventive services are covered when they are received in-network. Preventive benefits are payable at 100 percent of the approved amount. **These services are not covered out-of-network, with or without a referral.**

- **Health maintenance exams** – covers one per member per calendar year which includes a comprehensive history and physical examination, and the following laboratory and radiology procedures:
  - Chemical profile
  - Complete blood count
  - Urinalysis
  - Chest X-ray
  - EKG
- **Gynecological exams** – covers one per member per calendar year.
- **Pap smear screening (laboratory services only)** – covers one per member per calendar year when prescribed and performed by a PPO physician. More frequent pap smears are covered because of the suspected or actual prescence of a disease or when required as a post-operative procedure.
- **Well-baby and child care visits** – covers routine visits to a physician to monitor the development and well being of children. These visits are covered through age 15 as follows:
  - Six visits per year through age 1
  - Two visits per year, age 2 through 3
  - One visit per year, age 4 through 15

- **Immunizations** – covers immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics, including Hepatitis B and HIB.

- **Fecal occult blood screening** – covers one per member per calendar year.

- **Flexible sigmoidoscopy exams** – covers one per member per calendar year.

- **Prostate specific antigen (PSA) screening – covers PSA screenings as needed.**

Prescribed Contraceptive Devices

Your benefits include coverage for physician-prescribed contraceptive devices such as diaphragms, intrauterine devices or contraceptive implants designed to prevent pregnancy. This benefit is part of your medical-surgical coverage. Contraceptive devices are subject to the same deductible you pay for medical-surgical services. You only have a copayment when you receive services from a non-network provider.

Contraceptive Injections

Administration of injectable contraceptive medications, as well as the cost of the medication, is payable under your medical-surgical coverage when provided by your physician. Contraceptive medication you obtain from a pharmacy is not covered under your medical-surgical coverage. When your physician injects contraceptive medication you purchased from a pharmacy, only the administration is payable under your medical-surgical coverage. The medication may be covered under your prescription drug coverage.

Contraceptive injections are part of your medical-surgical coverage, subject to the same deductibles and copayments you pay for medical-surgical services.

Office Visits

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

Allergy Services

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

Chiropractic Services

Your benefits include the following chiropractic services:

- **New patient office visits** – covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.

- **Office visits** – covers one per member every calendar year for established patients.

- **Chiropractic traction** – number of payable visits is determined by your physical therapy benefit.

- **Chiropractic manipulation** – limited to one per day, up to a maximum of 24 medically necessary visits each calendar year.

Maternity Care

Your benefits include delivery and pre-and post-natal services. The initial inpatient examination of the newborn is a benefit when performed by a physician other than the anesthesiologist or the delivery physician.

Note: *Maternity care benefits also are payable when provided by a certified nurse midwife. Delivery must be in a hospital or BCBSM-approved birthing center.*

Surgical Services

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

- **Multiple surgeries** (two or more surgical procedures performed by the same physician during one operative session) are subject to the following payment limitations:
  - When surgeries are through **different** incisions, BCBSM will pay the approved amount for the most costly procedure and one half of the approved amount for the less costly procedure.
  - When the surgeries are through the **same** incision they are considered related and BCBSM will pay the approved amount for the more difficult procedure.

Reminder: *PPO network and Blue participating providers accept the BCBSM approved amount as payment in full. However, nonparticipating providers may bill you for the difference.*

- **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars, and for correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- **Breast reconstruction surgery** is covered for:
  - Reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

- **Dental surgery** is covered only for the removal of impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition exists, such as a heart condition.

Your surgical services also include:

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

- **Anesthesia** – Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to certified registered nurse anesthetists. Blue Cross Blue Shield of Michigan does not pay for local anesthesia.

Temporomandibular Joint Syndrome (TMJ) or Jaw Joint Disorder

Benefits for TMJ or jaw-joint disorder are limited to surgery directly to the jaw joint, X-rays (including MRIs), and arthrocentesis (injection procedures). Other than the exceptions noted, benefits are not payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint, skull and the muscles/nerves/tissue related to the jaw joint. These exclusions include (but are not limited to): crowns, inlays, caps restorations, grindings, orthodontics, dentures, partial dentures or bridges.

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

Note

- ***Irreversible*** *treatment of the mouth, teeth, or jaw is intended to bring about permanent change to a person's bite or position of the jaws. It includes but is not limited to dentures, bridges, crowns, caps, inlays,* ***restorations, grinding and orthodontics.***

- ***Reversible*** *treatment of the mouth and jaw is not intended to result in permanent alteration of the bite or position of the jaws; it is directed at managing the patient's symptoms.*

Inpatient Medical Care

Medical supervision by a physician is payable while you are in the hospital or in a skilled nursing care. Inpatient medical care in a skilled nursing facility is limited to two visits per week.

Inpatient and Outpatient Consultations

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

Diagnostic and Radiation Services

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

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

- **Laboratory and pathology tests.**

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

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

- **Mammography screening** – includes one screening per member per calendar year, regardless of age. More frequent mammograms are covered if prescribed by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.

Other Covered Services

Your coverage includes the following services:

Cardiac Rehabilitation for Phases II and III

Cardiac rehabilitation must be performed by a licensed physician (MD/DO), or under the direct supervision of a licensed physician.

To be payable, the following requirements must be met:

- The patient has had an inpatient or outpatient treatment within six months of referral for a cardiac diagnosis or has at least one admission for an inpatient or outpatient cardiac diagnosis.

- The patient must have a physician's order

- The patient must be age 16 or older.

Phase II benefits:

- A two to six week program (up to 18 visits, depending upon medical criteria), that follow an inpatient admission or outpatient admission for a cardiac condition. Re-assessment occurs after two weeks. (Phase II may be extended if medically necessary and appropriate.)

- Complete medical history

- Stress test monitoring

- Lipid Profile

- EKG

Phase III benefits:

- Additional six-week program to reinforce lifestyle changes introduced in Phase II

- Medical evaluation

- Stress test without EKG monitoring

- Lipid Profile

- Three exercise sessions per week that are not monitored

- Educational sessions (minimum of one per week)

Benefits are payable at 100 percent of the approved amount (no copayment) for covered services. The Case Management Department will administer benefits under this program. Pre-authorization is required before any services are covered.

Patient(s) with Medicare as their primary insurer will not be eligible for these benefits. The patient must be primary on the BCBSM group contract (no coordination of benefits).

Medical Supplies

Blue Cross Blue Shield of Michigan will pay for medical supplies and dressings for use in the home when prescribed by a physician for the treatment of a specific medical condition.

Durable Medical Equipment (DME)

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

Your coverage **does <u>not</u>** pay for:

- Exercise and hygienic equipment

- Comfort and convenience items

- Self-help devices, such as elevators

- Deluxe equipment, such as motorized wheelchairs unless medically necessary and required so the patient can operate the equipment themselves

- Experimental or investigational equipment.

Prosthetic and Orthotic Appliances

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

Benefits are also payable for orthotic inserts (custom orthotics) and orthopedic shoes. Benefits are limited to one pair, per member per calendar year for orthotic inserts and/or shoes.

Note: *Orthopedic shoes do not have to be attached to a medically necessary brace to be payable.*

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

Your coverage **does <u>not</u>** pay for:

- Non-rigid devices and supplies such as elastic stockings
- Garter belts, arch supports and corsets
- Hearing aids
- Hair prosthesis such as wigs or hair implants.

Private Duty Nursing

Nursing services are covered in your home when medically necessary and required on a 24-hour basis. Services must be prescribed by a physician and provided by a registered or licensed practical nurse who is not related to or living with the patient. The attending physician must complete a Certification Statement each month the patient is required to have private duty nursing care.

Professional Ambulance Services

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

Your coverage **does <u>not</u>** pay for:

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

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

<u>What's Not Covered</u>

Your Community Blue PPO coverage **does <u>not</u>** cover:

- Pre-marital or pre-employment examinations.

- Care and services available at no cost to you in a veterans, marine, or other federal hospital or any hospital maintained by any state or governmental agency.

- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office setting.

- Custodial care, rest therapy, and care in nursing or rest home facilities.

- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists.

- Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than direct surgery on the jaw joint, arthrocentesis (injections) or X-rays.

- Eye examinations and eyeglasses or other corrective vision appliances.

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

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

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

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

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

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

- Psychological tests for vocational guidance or counseling.
- Services and supplies that are not medically necessary according to accepted standards of medical practice.

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

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

- Care and services 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 Community Blue PPO.

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

- Cosmetic surgery and related services solely for improving appearances except as specified in this booklet.

- Treatment of a condition caused by military action or war, declared or undeclared.

- Services, care, devices or supplies considered experimental or investigational.

- Services for which a charge is not customarily made; services for which the patient is not obligated to pay or services without cost.

- Examination, preparation, fitting, or procurement of hearing aids.

- Tests other than those identified in the Benefit sections of this booklet that are not required in and related to the diagnosis of an illness of injury.

- Dialysis services after 33 months of ESRD treatment.

- Services that are not included in your plan coverage documents.

- Transportation and travel except as specified in this booklet.

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

- Screening services, unless otherwise stated, excluding mammograms.

- Deductibles or copayments paid by the member under any other certificate.

- Physical therapy services performed by a chiropractor.

- Services, care, supplies, or devices **not** prescribed by a physician.

- Services provided during non-emergency medical transport.

- Non-emergent services at a nonparticipating hospital.
- Voluntary abortions.

Section 8. Prescription Drug Coverage

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

What's Covered

You have coverage for:

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

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

Generic Equivalent Drugs

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

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

- If your doctor prescribes a brand name medication to be "dispensed as written" when a generic alternative is available. The doctor must write "Dispense as Written" or "DAW" on the prescription.

- **If you request the brand name drug (not your doctor),** you must pay the difference between the BCBSM approved amount for the brand name drug and maximum allowable cost for the generic equivalent, in addition to your copayment.

Co-Branded Drugs

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

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

Your Copayment

Your copayment is:

- **$20** for each generic drug

- **$40** for each brand name drug, even if the prescription is marked "DAW" or if there is no generic equivalent drug available.

Choosing Your Pharmacy

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

Network pharmacy

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

When your prescriptions are filled through a **network** pharmacy, BCBSM will pay 100 percent of the approved amount less your copayment.

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

Medco Health Group Number: BCBSMLG

If your pharmacist needs assistance, he or she may call the Medco Health Pharmacy Services Help Desk at 1-800-922-1557.

Non-Network Pharmacy

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

What's Not Covered

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

- Drugs that cost less than your copayment
- Administration of covered drugs or any covered drug entirely consumed at the time and place of the prescription
- Refills not authorized by a physician

- Any medication that does not require a prescription, except insulin
- Therapeutic devices or appliances, even if prescribed by a physician (e.g., support garments regardless of their intended use)
- The charge for any prescription refill in excess of the number specified by the prescriber
- Refills dispensed after one year from the date of the original order
- More than a 34-day supply of a covered drug, except for specified maintenance drugs that are covered for 100-unit doses or 200-unit doses (retail pharmacy)
- Prescription drugs that are used primarily for improving appearance rather than for treating a disease
- Diagnostic agents
- Any vaccine given solely to resist infectious diseases
- Any drug BCBSM determines to be experimental or investigational
- Drugs or services payable by government-sponsored health care programs, such as Medicare, for which you are eligible
- Drugs or services obtained before the effective date of coverage or after the coverage termination date
- More than 12 doses of an impotence drug such as Viagra in a 34-day period
- Nonpreferred co-branded drugs, unless they are preauthorized
- Any drug or device prescribed for "indications" (uses) other than those specifically approved by the Federal Food and Drug Administration
- Drugs that are not labeled either, "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only", except for state-controlled drugs.

Section 9. Medicare Coverage for Eligible Members

Medicare Coverage

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

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

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

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

Employed Persons Aged 65 or Older

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

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

2. Select Medicare as your primary health care plan.

The following explains these options:

Option 1

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

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

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

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

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

Option 2

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

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

Medicare Supplemental Coverage

If you have Supplemental coverage, it works with your Medicare coverage to extend your health care benefits. Note: You must enroll in both Part A and Part B of Medicare to be eligible for Supplemental benefits.

What's Covered

You have coverage for the following:

- **Part A Benefits**
- **Inpatient hospitalization** – covers your Medicare Part A deductible and coinsurance required from the 61st day through the 90th day of a hospital admission. It also extends the number of your inpatient days to 365.
- **Lifetime reserve days** – covers the daily coinsurance required by Medicare.
- **Skilled nursing care** – covers the daily coinsurance required by Medicare for days 21 through 100.
- **Part B Benefits**
- **Physician care** – covers the yearly deductible required by Medicare and 20 percent of Medicare's reasonable charge.
- **Outpatient psychiatric care** – covers the special 50 percent coinsurance required by Medicare in addition to the 20 percent coinsurance for physician care.

What's Not Covered

Your Medicare Supplemental coverage **does <u>not</u>** cover:

- Custodial nursing care (such as help with walking, getting in and out of bed, eating, dressing, bathing and taking medications) at home or in a nursing home
- Intermediate nursing care in a nursing home
- Private duty nursing or skilled nursing care not approved by Medicare
- Physician charges that are more than Medicare's allowed amount
- Injury or sickness covered by Workers Compensation
- Admissions or care provided by a government owned or operated hospital unless payment is required by law
- Admissions that begin before the effective date of coverage
- Admissions that begin after the coverage termination date
- Medical care, services or supplies provided or furnished while coverage is not in effect (that is, before the effective date of coverage or after the coverage termination date)

- Drugs other than prescription drugs furnished during your stay in a hospital or skilled nursing facility
- Dental care, dentures, routine physicals and immunizations, cosmetic surgery, routine foot care, and examinations for eyeglasses or hearing aids

Section 10. To File a Claim

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

To file your own claim, follow these steps:

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

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

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

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

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

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

1. NAME AND ADDRESS OF PROVIDER*
2. FULL NAME OF PATIENT
3. DATE OF SERVICE
4. CHARGE
5. DIAGNOSIS AND TYPE OF SERVICE

PHYSICIAN RECEIPT

1 George S. Smith, M.D.
100 Market Street
Hometown, State

2 For professional services to:
John Doe

3 4 5

DATE OF SERVICE	CHARGE	DIAGNOSIS/SERVICE
5-31-90	$25.00	Anemia/Office visit
6-11-90	$15.00	Sprained Ankle/ X-Ray, Ankle
5-22-90	$8.00	Anemia/Complete Blood Count
6-5-90	$15.00	Sprained Ankle/ X-Ray, Ankle
6-3-90	$8.00	Anemia/Complete Blood Count

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

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

Major Accounts Service Center, **Mail Code X420**
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Explanation of Benefit Payments (EOBP)

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

- The family members who received services.
- The date services were provided ("claims processed from….to….").
- **"Summary of Balances"** includes the provider(s) of the services, detail about charges and payments, including the amount saved by using network providers.
- **"Summary of Deductibles and Copayments"** provides your deductible and copayment requirements as well as deductibles and copayments paid to date.
- **"Helpful Information"** includes messages and reminders.
- **"Details on Services"** summarizes the BCBSM payment and shows your balance.

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

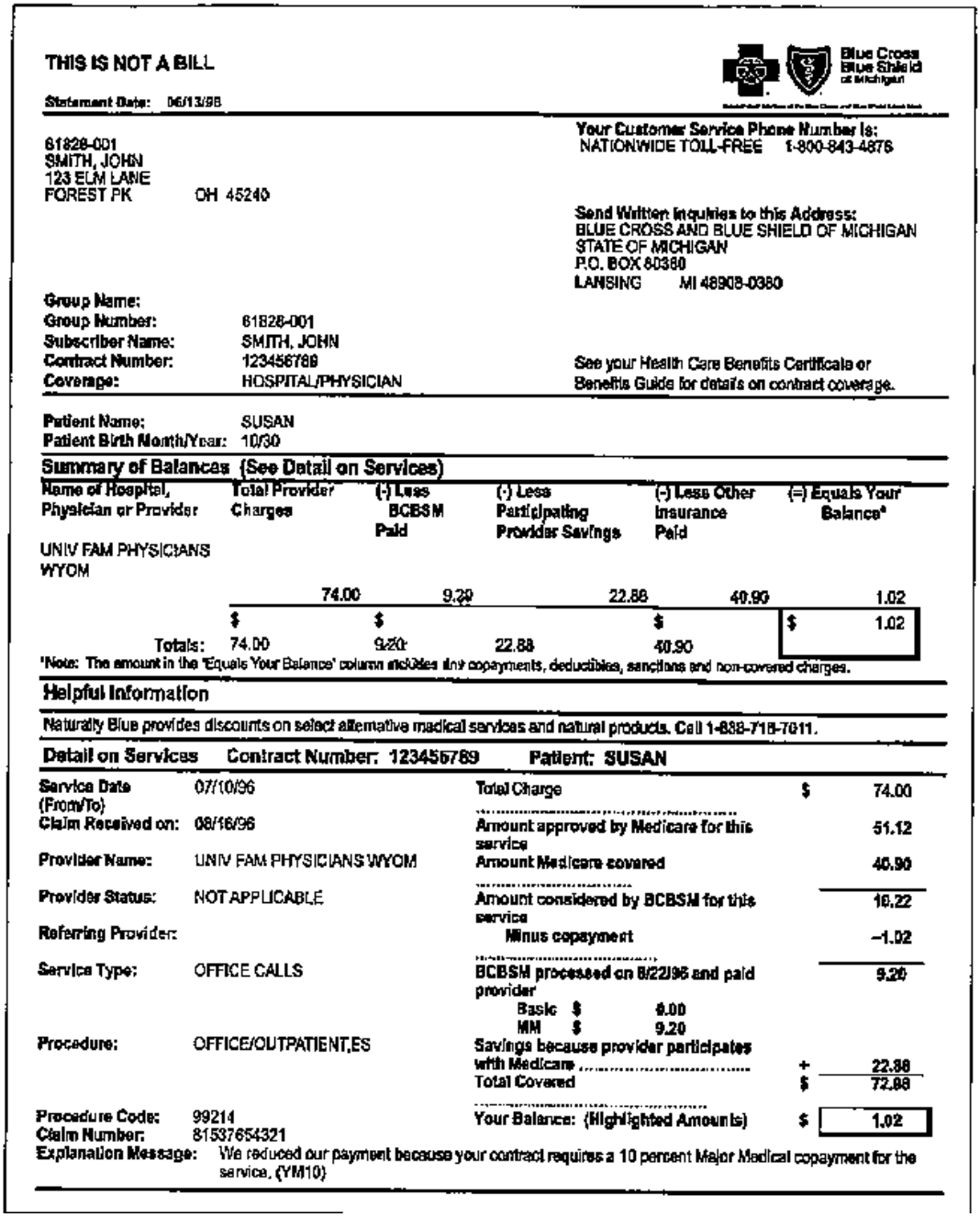
If you think your provider is intentionally billing us for services you did not receive, or that someone is using your card illegally, please contact our Anti-Fraud Hotline.

- If your health care coverage is through BCBSM, call our Anti-Fraud Hotline at **1-800-482-3787.** Your call is strictly confidential.
- Write us at the following address:

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

- Contact us online at **www.bcbsm.com/antifraud/contact.shtml**

EXAMPLE OF EOB



THIS IS NOT A BILL

Blue Cross Blue Shield of Michigan

Statement Date: 06/13/96

61828-001
SMITH, JOHN
123 ELM LANE
FOREST PK OH 45240

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

Send Written Inquiries to this Address:
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
STATE OF MICHIGAN
P.O. BOX 60360
LANSING MI 48908-0360

Group Name:
Group Number: 61828-001
Subscriber Name: SMITH, JOHN
Contract Number: 123456789
Coverage: HOSPITAL/PHYSICIAN

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

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

Summary of Balances (See Detail on Services)

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

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

Helpful Information

Naturally Blue provides discounts on select alternative medical services and natural products. Call 1-888-716-7011.

Detail on Services Contract Number: 123456789 Patient: SUSAN

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

Total Charge	$	74.00
Amount approved by Medicare for this service		51.12
Amount Medicare covered		40.90
Amount considered by BCBSM for this service		10.22
Minus copayment		-1.02
BCBSM processed on 8/22/96 and paid provider		9.20
Basic $ 0.00		
MM $ 9.20		
Savings because provider participates with Medicare	+	22.88
Total Covered	$	72.88
Your Balance: (Highlighted Amounts)	$	1.02

Procedure Code: 99214
Claim Number: 81537654321
Explanation Message: We reduced our payment because your contract requires a 10 percent Major Medical copayment for the service. (YM10)

Coordination of Benefits (COB)

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

How COB Works

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

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

Guidelines to Determine Primary and Secondary Plans

Contract Holder Versus Dependent Coverage

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

Contract Holder (Multiple Contracts)

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

Dependents (The "Birthday Rule")

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

Children of Divorced or Separated Parents

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

1. Plan of the custodial parent.

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

3. Plan of the non-custodial parent.

4. Plan of non-custodial parent's new spouse.

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

Filing COB Claims

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

1. Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.

2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.

3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.

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

5. Send these items to:

   COB Department, Mail Code B570
   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 Blue Cross Blue Shield cannot return the originals to you.

Update 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 Blue Cross Blue Shield serve you better by responding to requests for COB information quickly.

Subrogation

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

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

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

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

No-Fault Auto Insurance and BCBSM Coverage

If you or an eligible dependent are involved in a motor vehicle accident, BCBSM will not pay for services related to an injury which is a direct or indirect result of an automobile accident. This applies whether or not you have no-fault automobile insurance. It is important that you discuss this with your auto insurance company.

Section 11. Glossary – Terms You Should Know

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

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

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

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

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

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

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

Approved Facility – A hospital or clinic that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care, or physical therapy. Approved facilities **must** meet all applicable local and state licensing and certification requirements. Approved facilities must be accredited by the Joint Commission on

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Routine nursing care

- Training in personal hygiene and other forms of self-care

- Care supervised by a physician

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Necessity – Unless stated otherwise, a service must be medically necessary in order to be covered. There are two definitions: one applies to physician services and one applies to hospital services. Reference applicable sections in this booklet for further information or a complete description refer to your certificates and riders.

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

Network Pharmacies – Pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Preferred Rx network (in Michigan) or Medco Health Prescription Solutions network (outside Michigan). Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

Network Providers – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with Blue Cross Blue Shield to provide services to members enrolled in the Community Blue PPO plan.

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

Non-Network Providers – Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services through the Community Blue PPO program.

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

Occupational Therapy – A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- Develop, improve or restore the performance of necessary neuro-musculoskeletal functions affected by an illness or injury, or following surgery

- Help the patient 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, bath stools, large handle eating utensils, lap trays and raise toilet seats).

Out-of-Network Service – A service not performed or referred by a PPO provider.

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

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

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

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

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

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

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

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

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

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

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

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

Self-Management Training – An interactive, collaborative process involving patients with diabetes, their physicians and certified diabetes instructors. The training provides these members with the knowledge and skills needed to care for themselves on a day-to-day basis, manage diabetic crises and make any lifestyle changes needed to manage the disease successfully.

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

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

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

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

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

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

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

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

To Order Certificates and Riders

Your Benefits Guide booklet is a summary of your benefits. It is not your contract. While every effort has been made to make this booklet accurate and complete, your official benefits and conditions are contained in your certificates and riders. (The codes are listed on the inside of the back cover.) **Your certificates and riders are available on request but they are NOT needed to obtain benefits.**

To obtain these certificates and riders, please complete the information below and mail this form to:

Mail Code L806
Blue Cross Blue Shield of Michigan
600 E. Lafayette
Detroit, MI 48226-2998

Be sure to include the subscriber's first and last name, address, and contract number. Please verify that the five-digit group number below is the same as it appears on your BCBSM identification card.

GROUP NAME: Michigan Carpenters' Health Care Fund

GROUP NUMBER/SUFFIX _____
GROUP NUMBER SUFFIX

SUBSCRIBER'S NAME: _____
FIRST LAST

CONTRACT NUMBER: _____

STREET ADDRESS: _____

CITY/STATE/ZIP CODE: _____

These are the codes for your certificates and riders and are for internal use by BCBSM:

C 2232-ASCMOD 1747
C 3383-NFAX-2
C 4398-BONE MRRW TRANS
C 4725-XVA
C 5160-CB-ET $0
C 5220-SUBR02
C 5227-HMN
C 5401-SOCT
C 5423-END STAGE RENAL
C 5549-CB-MHDV 10%
C 5756-CBC 10% P
C 5812-CB-PCM
C 5815-CB-CMP $500/90
C 5821-ASFP
C 6003-ICMP
C 6225-COMM BLUE BASIC
C 7292-PTFS-COMPS
C 9770-GRP CONTINU OPT
C 990903-SOT-PE
C993009-GLE-1
D 2617- $10/$40 RX
D 3607-PREFERRED RX
D 513814-PDCM PDCR$10.00
S 2232-ASCMOD 1747
S 3383-NFAX-2
S 3687-CERT NURSE PRAC
S 4398-BONE MRRW TRANS
S 4725-XVA
S 5160-CB-ET $0
S 5216-ECIP
S 5220-SUBR02
S 5315-CI
S 5385-CRNA
S 5401-SOCT
S 5423-END STAGE RENAL
S 5549-CB-MHDV 10%
S 5756-CBC 10% P
S 5812-CB-PCM
S 5815-CB-CMP $500/90
S 6217-PTS-PSG
S 6225-COMM BLUE BASIC
S 6600-CNM
S 6603-CB-PCB
S 7469-RAPS
S 9770-GRP CONTINU OPT
S 9973-PCD
BCP BCP-PPO MLOS
COB2B FC

C180E6	07/01/1999
S1Y0GD	07/01/1999
C180E6	07/01/1999
S1Y0GD	07/01/1999

Service Key	**Effective Date**
C180E6	07/01/1999
S1Y0GD	07/01/1999

These are the codes for your certificates and riders and are for internal use by BCBSM:

C 2232-ASCMOD 1747
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C 9770-GRP CONTINU OPT
C 990903-SOT-PE
C993009-GLE-1
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D 3607-PREFERRED RX
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S 4725-XVA
S 5160-CB-ET $0
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S 5315-CI
S 5385-CRNA
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S 5423-END STAGE RENAL
S 5549-CB-MHDV 10%
S 5756-CBC 10% P
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S 6600-CNM
S 6603-CB-PCB
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COB2B FC

C180E6	07/01/1999
S1Y0GD	07/01/1999
C180E6	07/01/1999
S1Y0GD	07/01/1999

Blue Cross Blue Shield of Michigan provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Service Key	**Effective Date**
C180E6	07/01/1999
S1Y0GD	07/01/1999

Group No 10979/all suffixes **January 30, 2003/RE**

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Section 12: Retiree Flex Benefits

Flex Benefits provide Supplement to Medicare participants with reimbursement of Prescription Drug expenses for eligible services and purchases.

Eligible expenses may be reimbursed up to 90%. Flex Benefits are limited to a maximum of $750 per family, per fiscal year (September 1 through August 31).

To obtain reimbursement for Flex Benefits, participants must complete a claim form and return it with itemized bills directly to the Fund Office.

The itemized bills should include the participant's name, Social Security number, the patient's name, the date of service or purchase, the type of services performed and the provider's name, address and tax identification number.

The Fund Office will reimburse the participant directly for Flex Benefits. Participants on the Supplement to Medicare Program, who use Flex Benefits for reimbursement of prescription expenses, must first pay for the prescription then submit the prescription to the Fund Office for reimbursement.

Flex Benefits will be reviewed annually and may be discontinued at the end of the fiscal year unless extended by the Trustees.

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Section 13: Alternative Minimum Coverage Program

Eligibility Provisions

Active employees who are maintaining eligibility by way of the Fund's regular Self-Contributions Program and are remitting self-contributions or remitting self-payments under the Early Retiree Self-Payment Program are eligible for the Alternative Minimum Coverage Program.

Method of Payment for Coverage

Self-payments for the Alternative Minimum Coverage Program must be postmarked by the 20th of the month preceding the month for which payment is being made.

Provisions for Continued Participation

The participant may continue coverage under the Alternative Minimum Coverage Program until one of the following occurs:

1. Failure to remit self-payment on time or in the proper amount
2. Non-validation by a participating Local Union that a participant is unemployed but available for work within the jurisdiction of the Fund or has insufficient hours to maintain eligibility
3. Termination or modification of the Alternative Minimum Coverage Self-Payment Program
4. Death of the participant.

Special Provisions

Credit will be given for employer contributions made to the Fund in the participant's behalf while remitting payments under the Alternative Minimum Coverage Self-Payment Program. In addition, he may NOT revert to self-contribution coverage following election of Alternative Minimum Coverage unless he re-establishes via the Plan's regular eligibility provisions. Early Retiree participants may, however, revert to the Retiree Self-Payment Program.

The following information explains the burial and accidental death and dismemberment benefits available to you.

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Section 14: Burial and Accidental Death and Dismemberment Benefits

Burial Benefits

Burial benefits are payable to the beneficiary upon the death of an eligible participant or participant's spouse according to the following schedule:

Participant $4,000
Spouse $1,000

Written notice of the death of a covered person must be given to the Fund Office within one (1) year of the date of death of the Covered Person, otherwise no burial benefit will be payable. No burial benefits are payable if the death of the covered person is the result of felonious activity or aggravated assault.

Retiree Burial Benefits

Burial benefits are payable to the beneficiary upon the death of a Retired Participant or the Retired Participant's Spouse according to the following schedule:

Retired Participant $1,000
Spouse $1,000

The Retired Participant must meet the following eligibility requirements:

- He must have been eligible under the Active Program in five (5) of the ten (10) years immediately preceding his date of retirement.
- He must be retired and receiving monthly benefits from one of the following:
  - The Michigan Carpenters' Pension Fund
  - The Detroit Carpenters' Pension Fund
  - The Social Security Administration.
- He must remain a member in good-standing with his local union. His status will be check upon retirement and once each year thereafter.
- If he retired on or after September 1, 1986, he must be eligible by self-payments under the Early Retiree Self-Payment Program, the Totally and Permanently Disabled Participant Self-Payment Program or the Supplement to Medicare Program on the date of death for benefits to be payable.

- If he retired prior to September 1, 1986 and is receiving a monthly benefit from the Michigan Carpenters' Pension Fund, he may also be eligible for a $1,000 Benefit.

- For his spouse to be covered for the Retiree Spouse's Death Benefit, self-payments must be made under either the Early Retiree Self-Payment Program, the Retiree Self-Payment Program, the Totally and Permanently Disabled Participant Self-Payment Program or the Supplement to Medicare Program to provide her with coverage.

- A Participant Data Card should be completed by the Retired Participant. This card is used to designate his beneficiary. The Retired Participant is automatically the beneficiary for his spouse. His spouse cannot designate a beneficiary. Refer to the sub-section, "Beneficiary," for further beneficiary information.

- Benefits will be paid to the Beneficiary designated on the latest Participant Card on file in the Fund Office on the date of death.

  – In the event the Retired Participant has not filed a Participant Data Card, benefits will be paid to his surviving legal spouse.

  – If he is not survived by a spouse, benefits will be paid, equally, to his surviving children.

  – If he is not survived by either a spouse or children, benefits will be paid to his surviving parents.

  – If he is not survived by a spouse, children or parents, benefits will be paid to his estate or any individual determined by the Board of Trustees to be equitably entitled to receive the Burial 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.

- The designated beneficiary for receipt of burial benefits will also be the beneficiary for any medical expenses that had not been paid before the date of death.

Accidental Death and Dismemberment Benefits

When a bodily injury caused solely through external, violent or accidental means, on or off the job, while an Employee is eligible by either employer contributions or active self-contributions shall directly and independently of all other causes result in any of the following losses, within 90 days after the accident, the Plan will pay benefits for losses described in the following Schedule. This benefit shall be paid in addition to any other benefits that may be payable by the Plan and is not subject to coordination of benefits.

LOSS OF

Life	$5,000
Both hands or both feet	$5,000
One hand and one foot	$5,000
One hand or one foot & entire sight of one eye	$5,000
One hand or one foot	$2,500
Entire sight of one eye	$2,500
Entire sight of both eyes	$5,000

With reference to hand or foot, "loss" means complete severance through or above the wrist or ankle joint and with reference to eye, means the irrecoverable loss of the entire sight of the eye. Benefits will not be paid for more than one (1) of the losses (the greatest) sustained by the Covered Employee as the result of any one (1) accident.

No Accidental Death or Dismemberment Benefits are payable if the death or injury of the eligible Participant is the result of a felonious activity, aggravated assault or suicide.

Beneficiary

As used herein, "Beneficiary" means the person or person designated to receive any benefits upon the death of an Eligible Employee, Retired Participant, or the legal Spouse of such Eligible Employee or Retired Participant. The designation of a Beneficiary shall be initially made by the Employee when he completes a Participant Data Card with the Fund Office.

Any Employee may thereafter designate a Beneficiary or change his designated Beneficiary at any time, without consent or knowledge of the Beneficiary, by filing with the Fund Office a new, completed Participant Data Card. A change of Beneficiary will be effective upon receipt in the Fund Office of the newly completed Participant Data Card.

Employees who once were but now are no longer married should be certain to change their Participant Data Card. Otherwise, their benefit could be paid to an unintended person, such as a former spouse.

If no Beneficiary has been designated, any benefits payable upon the death of an Employee will be paid to his surviving legal spouse. If there is no surviving legal spouse, benefits are paid to his surviving children. If there are no surviving children, benefits are paid to his surviving parents. If there are no surviving parents, benefits are paid to the estate of the deceased Employee.

The Employee shall automatically be deemed to be the Beneficiary for the payment of any benefits upon the death of his legal spouse. The spouse of an Eligible or Retired Participant shall not be entitled to designate a Beneficiary under the Plan.

Benefits may be assigned, by the designated beneficiary, directly to the Funeral home. Assignment of benefits by any individual(s) other than the designated beneficiary will not be honored.

The Beneficiary must submit written claim for benefits within one (1) year from the date of death.

The designated beneficiary for receipt of death benefits will also be the beneficiary for any medical expenses that had not been paid before the date of death.

The following information is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA).

Section 15. Claims Review & Appeal Procedures

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

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

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

If you have questions about decisions made on claims of requests for other Fund benefits, you should address them by telephone to one of the Fund Office's claims representatives. Their telephone number is (800) 273-5739.

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

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

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

An "urgent care claim" is a claim for medical care or treatment where applying the normal time periods for claims determination could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician who knows your medical condition, would

subject you to severe pain that cannot be adequately managed without the care or treatment that you are seeking.

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

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

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

Medical Benefit Claim Review Procedure

A. Review Procedure – Post-service claims

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

Level 1. To start a Level 1 review, you, or your authorized representative, must send a written statement to BCBSM explaining why you disagree with the Plan's adverse benefit determination.

The mailing address is found at the top right hand corner of the first page of your Explanation of Benefits form and in the letter we sent notifying you that the Plan has not approved a benefit or service that you have requested.

You must include in your request all documents, records or comments that you believe support your position. You must request review no later than 180 calendar days after you receive the Plan's decision on your claim for benefits. BCBSM will respond to your request for

review within 30 days unless BCBSM tells you in writing that it needs additional time. If you agree with BCBSM's response, it becomes a final determination and review of your claim ends.

Level 2. If you disagree with BCBSM's Level 1 response to your request for review, you may request a review by the Plan's Trustees at Level 2. You must request Level 2 review in writing no later than 30 calendar days after you receive our Level 1 determination.

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

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

B. Review Procedure – Pre-service claims

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

2. If you disagree with the final determination, or if the determination at each level is not issued within the 15 day time frame or the review procedures for level 1 and level 2 are otherwise not

complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

C. Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call: (313) 225-6800.

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

3. If you disagree with the BCBSM final determination or if they fail to issue the determination within 72 hours, or otherwise fail to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

   In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims.

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

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

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

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

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

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

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

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

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

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

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

Claim Review Procedure for Other Benefits

The Plan's review procedure for these claims has a one-step appeal process. It is triggered when the Plan provides you with a written adverse benefit determination, which must be done within 180 calendar days of the Plan's receipt of your claim. The Plan's Appeals Committee will decide your request no later than its first regular meeting that is at least 30 days after the Trustees receive your appeal. The written determination that you receive as a result of your Level 1 request for review will be the final determination involving your claim for benefits.

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

Section 16. Information Required by ERISA

Type of Plan

The Plan provides health care and prescription drug coverage, burial benefits, and accidental death and dismemberment benefits.

Amendments

The Trustees reserve the right to amend the Plan at any time and from time to time. If the amendment materially changes the provisions of the Plan as outlined in this summary, a new Summary Plan Description or Supplement will be furnished to Participants.

Name of Plan Administrator

The Michigan Carpenters' Health Care Fund is maintained and administered by a Board of Trustees. There are six (6) Labor Trustees and six (6) Management Trustees on the Board. A list of the current Trustees is in the Appendix, "Board of Trustees."

The Board of Trustees has the primary responsibility for decisions regarding the eligibility provisions, type of benefits, administrative policies, management of Fund Assets, and interpretation of Fund documents, provisions and terms.

Plan Year

The Plan year operates on a fiscal year basis commencing September 1 and ending on August 31 of the following year. Remember, your Master Medical program copayment stop-loss and benefit dollar maximums are determined based on the calendar year.

Identification Numbers

The Michigan Carpenters' Health Care Fund has been assigned employer identification number 38-6058383 by the Internal Revenue Service and assigned to itself identification number 503 for the Department of Labor.

Type of Administration

Although the Board of Trustees are legally designated as the Fund administrator, they have delegated many of the day to day functions to TIC and Blue Cross Blue Shield of Michigan.

- TIC maintains the eligibility records, accounts for employer contributions and performs other routine activities under the direction of the Trustees.

- Blue Cross Blue Shield of Michigan processes claims, keeps participants informed about Plan changes and performs other routine activities under the direction of the Trustees for the health care and prescription drug coverage.

- TIC processes claims, keeps participants informed about Plan changes and performs other routine activities under the direction of the Trustees for burial benefits and accidental death and dismemberment benefits.

Collective Bargaining Agreements

The Michigan Carpenters' Health Care Fund was established and is maintained under the terms of collective bargaining agreements. The agreements set forth the conditions under which the participating employers are required to contribute to the Fund and the rate of contributions. Upon written request, Employees may examine the agreements at the Fund Office or at other specified locations. Employees may request a copy of the agreement which will be provided to them at a reasonable charge.

Plan Sponsors

The Fund is maintained under the terms of collective bargaining agreements negotiated by the Union with participating employers. Employers who agree in writing to make contributions to the Fund are considered "plan sponsors." If any employer is not a party to a written agreement then 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 about whether or not an employer is a contributing employer, your Union Office should be contacted.

Source of Contributions

The primary source of financing for the benefits provided under this Fund and for the expenses of Fund operations is employer contributions. The rate of contribution is identified in the collective bargaining agreements negotiated by the Union with participating employers. No money is ever deducted from an Employee's paycheck to pay for these benefits. But, under the terms of the Fund, a Participant may make self-payments to retain his eligibility if he is temporarily unemployed or temporarily disabled or does not work enough hours to satisfy the eligibility provisions. Participants in the Early Retiree, Total and Permanent Disability and Retiree Programs are required to make self-payments to maintain eligibility for themselves and their dependents. A portion of Fund assets are invested and this also produces additional Fund income to help defray administrative expenses.

Fund Medium for the Accumulation of Fund Assets

All contributions and investment earnings are accumulated in a trust fund.

ERISA Rights and Protections

Participants in the Michigan Carpenters' Health Care Fund are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all Plan documents including: insurance contracts, collective bargaining agreements, copies of all documents, such as detailed annual reports and Plan descriptions filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Trustees. Under ERISA, Trustees may make a reasonable charge for the actual cost of reproducing the documents and other information.

3. Receive summary of the Fund's annual financial report. The Fund administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

4. In addition to creating rights for Plan Participants, ERISA imposes duties on the people who are responsible for the operation of the Employee benefit plan.

   The people who operate this Fund, called Fund "fiduciaries", have a duty to do so with reasonable care and in the exclusive interest of Plan Participants and other Beneficiaries.

5. No one may take any action which would prevent a Participant from obtaining a benefit to which he is entitled under the Fund or from exercising his rights under ERISA.

6. In accordance with Section 503 of ERISA and federal regulations, the Trustees have adopted certain procedures to protect the rights of Participants who are not satisfied with the action taken on a claim. If a claim for benefits is denied, in whole or in part, the Participant must receive a written explanation of the reason for denial. Then, if the Participant is not satisfied with the action on the claim, he has the right to have the Trustees review and reconsider such claim in accordance with the Fund's claim review procedures.

7. If a Participant has any questions about the Fund, he should contact the Trustees by writing to:

   Board of Trustees
   Michigan Carpenters' Health Care Fund
   6525 Centurion Drive
   Lansing, MI 48917

8. Under ERISA, there are steps Participants can take to enforce their rights under the Fund. If materials are requested from the Fund and they are not received, or if the Participant feels that the Trustees or Employees are discriminating against him for asserting his rights under ERISA, he may seek assistance from the nearest Area Office of the United States Department of Labor or he may file suit in a Federal Court. However, the Fund provides appeal procedures and you must exhaust the Fund appeal procedures before taking other steps.
9. If a Participant has any questions about the foregoing statements or about his rights under ERISA which have not been answered in this booklet or by the Fund Office, he should contact the nearest 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.

Appendix

Employer Trustees

Duane Bremer
Gerace Construction Company
4055 S Saginaw Road
Midland, MI 48640-8501

Don Bovre
Michigan Chapter, AGC
2323 North Larch Street
Lansing, MI 48906

Stanley Buell
Grand River Construction Inc.
5210 36th Street
Hudsonville, MI 49426

Wayne Johnson
Gundlach Champion
P.O. Box 849
Tri City Industrial Park
Marquette, MI 49855

Hazel Leonard
Kreighoff-Lenawee
Box 100
Adrian, MI 49221

Robert Root
Forrester Construction
PO Box 606
Flint, MI 48501

Employee Trustees

Michael Donnelly
150 Old Kiln Road
Marquette, MI 49855

Tyler McCastle
2310 West Washtenaw Avenue
Lansing, MI 48917

Gary Isham
6459 W Pierson Road
Flushing, MI 48433

Dave Miller
6459 W Pierson Road
Flushing, MI 48433

John Nagelhout
140 North 64th Avenue
Coopersville, MI 49404

David Stark
140 North 64th Street
Coopersville, MI 49404
Flint, MI 48501

Agent for Services of Legal Process

Christopher P. Legghio
Martens, Ice, Geary, Klass, Legghio, Israel
and Gorchow, P.C.
1400 North Park Plaza
17117 West Nine Mile Road
Southfield, MI 48075

Administrative Manager for Plan

TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275
1-800-273-5739

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