UA LOCAL 190
HEALTH AND WELFARE PLAN

UA LOCAL 190
MEDICARE RETIREE HEALTH AND WELFARE PLAN

UA LOCAL 190
INDIVIDUAL HRA PLAN

SUMMARY PLAN DESCRIPTION

PROVISIONS IN EFFECT AS OF
JUNE 1, 2017

THE FOLLOWING HEALTH AND WELFARE BENEFITS ARE DESCRIBED IN THIS DOCUMENT:

Basic Benefits
(Medical and Hospital Coverage
as administered by
Blue Cross Blue Shield of Michigan)

Miscellaneous Benefits

Prescription Medicine Benefits

Individual Health Reimbursement Account

Life Insurance Death Benefit

Accidental Death and Dismemberment

Loss of Time Benefits

Dental Coverage
as administered by
Delta Dental Plan of Michigan, Inc.

Magellan HRSC, Inc.
Employee Assistance Program

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HEALTH AND WELFARE PLAN

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MEDICARE RETIREE HEALTH AND WELFARE PLAN

UA LOCAL 190
INDIVIDUAL HRA PLAN

INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

(referred to as the "SPD")

TO THE MEMBERS AND COVERED SPOUSES AND CHILDREN OF UA LOCAL 190 PLUMBERS/ PIPEFITTERS/ SERVICE TECHNICIANS/ GAS DISTRIBUTION:

We, as Trustees of the UA Local 190 Health and Welfare Plan, the UA LOCAL 190 Medicare Retiree Health and Welfare Plan, and the UA LOCAL 190 Individual HRA Plan ("Plan"), are constantly seeking to provide you and your families with the best available health care, at the most competitive prices. In previous years it was determined that the same high level of care that has historically been furnished you could be continued, at less cost, by making use of the Blue Cross Blue Shield of Michigan ("Blue Cross Blue Shield") administration and negotiated payment structure. Participating in the Blue Cross Blue Shield network also provides you with a Blue Cross Blue Shield card, facilitating the delivery of service to you.

Attached to this Introduction is a Summary Plan Description (SPD) of the Plan, which sets forth in detail eligibility requirements, coverages with Blue Cross Blue Shield, and additional coverages that continue to be provided by the Fund directly or through other organizations.

As you read this material, please remember that the Plan incorporates certain Blue Cross Blue Shield certificates and riders which describe benefits in technical detail and which we cannot include here. We have consolidated the certificates, riders and other modifications relating to medical coverage into a detailed Benefit Schedule that is available from the Administrative Manager at no cost upon request. The attached summary together with the detailed Benefit Schedule constitute the official Plan document. You may receive a copy of the entire official plan document and the contracts, certificates, riders and plan modifications under which the Plan is operated, upon written request to the Administrative Manager.

This summary is designed to provide you with the necessary information in most cases to give you a clear answer. We do ask you to spend some time reading it, and review it carefully whenever you have a situation where you have a question. The information should be there. Of course, the staffs of Blue Cross Blue Shield and of our Administrative Manager are always ready to help you when you can't find the answer. We simply urge you to read the material carefully before you call, as this will increase your information as to the benefits you have and make the whole process easier and more productive for all of us. Definitions of terms used in the text are at the end of the SPD. Please flip back there to look at the definitions to make your reading more understandable. Capitalized words are usually defined terms.

Blue Cross Blue Shield has participating agreements with most doctors and all licensed Michigan hospitals. Under these agreements the medical provider agrees to accept the negotiated fees as payment in full. We encourage you to use these providers whenever you can, as it is easier for you - just present your Blue Cross Blue Shield card and it is taken care of. There is no follow-through paperwork for you. You are also covered, but with limitations, if you use providers who do not participate with Blue Cross Blue Shield, but you and the Administrative Manager must go through a claim payment process, and the provider may bill you for amounts that exceed the amount Blue Cross Blue Shield normally pays for the same services.

In Section 7 there is a chart outlining Basic Benefits paid by Blue Cross Blue Shield and those paid for by you as a Participant. Section 8 provides a summary and specification of your Basic Benefits furnished through Blue Cross Blue Shield and the co-payments and limits on numbers of visits for certain types of services. This section is divided into three basic sections: a section describing how we pay for hospital and facility services, a section describing how we pay for physician and other health care provider services, and a section explaining other benefits that fall outside of the usual Blue Cross Blue Shield coverage, such as preventive care services and hearing care. Section 9 consists of a listing of Medical Coverage General Conditions, Exclusions and Limitations.

The additional health benefits paid directly by the UA Local 190 Health and Welfare Trust ("Fund"), described as Miscellaneous Benefits, are in the SPD section 10, designated "Miscellaneous Benefits and Prescription Medicine Benefits." The Delta Dental Plan of Michigan, Inc. ("Delta Dental") Benefits and exclusions are in Section 23. The Employee Assistance Program is set forth in Section 24, and is sometimes referred to as "EAP." Further benefits paid for by the Fund are the basic Life Insurance Death Benefit (Section 12), the basic Accidental Death and Dismemberment Benefit (Section 13) and Loss of Time Benefits (Section 14). Effective December 1, 2015, an optional, supplemental group term Life Insurance Death Benefit and an optional, supplemental group Accidental Death and Dismemberment benefit are available to Members, Spouses and Children (with the requirement that Children be between 15 days and 26 years old and supported by the Member) at Members' expense. Effective December 1, 2015, an optional, supplemental individual Whole Life Insurance benefit is available to Members, Spouses, Children and grandchildren at Members' expense.

This document also describes additional benefits in Section 11 that are provided under the UA Local 190 Individual HRA Plan and Trust. That separate plan provides benefits similar to the Miscellaneous Benefits through an individual health reimbursement account. Those benefits are governed by a separate plan but are summarized here for your convenience. References made in this document to "Plan" or "Fund" generally refer to all of these plans, unless the context or a specific reference makes it clear that the plans are treated differently. If there is a conflict between that plan document and this summary, the plan document controls. That plan is administered by a Board of Trustees consisting of the same Trustees who serve on the UA Local 190 Health and Welfare Plan and Trust board and the UA Local 190 Medicare Retiree Health and Welfare Plan board, and the same Administrative Manager, and all addresses regarding notification are also the same as for the Miscellaneous Benefit administration under the Health and Welfare Plan.

If you do not find the answer to your question in this Plan and SPD, you are always welcome to call the Administrative Manager's Office with questions relating to eligibility and the Blue Cross Customer Service office for questions regarding specific benefits. The names, addresses, and phone numbers of these offices are at the end of this SPD.

We hope this Introduction will assist you in reviewing the full SPD. Please be assured we will continue to do everything we can to improve and facilitate the health program for the benefit of all Members and their families.

The Trustees

SECTION 1

GENERAL PLAN INFORMATION, INFORMATION REQUIRED BY ERISA, RIGHTS AND OBLIGATIONS UNDER THE PLAN, AND ADMINISTRATIVE RULES

Sponsoring Organizations

The organizations that authorized the establishment of the Health and Welfare Plan and the Individual HRA Plan are:

UA LOCAL 190
PLUMBERS/ PIPEFITTERS/
SERVICE TECHNICIANS/ GAS DISTRIBUTION
EIN 38-0895168
7920 Jackson Road, Suite B
Ann Arbor, MI 48103

GREATER MICHIGAN PLUMBING &
MECHANICAL CONTRACTORS
ASSOCIATION, INC.
EIN 38-6087681
58 Parkland Plaza, Suite 600
Ann Arbor, Michigan 48103

The Fund is maintained under the terms of Collective Bargaining agreements negotiated by Local 190 with participating Employers. To obtain benefits under this Fund without the requirement of self-payment, a Participant must be working for a contributing Employer. If an employer is not a party to a written agreement, then that employer has no legal obligation to contribute to the Fund on behalf of the Participants and the Participants must pay their own contributions. If there is any uncertainty about whether or not an employer is a contributing Employer, your union office should be contacted. A complete list of all Employers contributing to the Plan is available from the Administrative Manager.

Plan Names

Effective June 1, 2015, the plan that was previously called the "UA Local 190 Health and Welfare Plan" has been divided into two separate plans, one for all Members other than Medicare-Eligible Retirees and the other for Medicare-Eligible Retirees only. The plan for Members other than Medicare-Eligible Retirees continue to be known as the "UA Local 190 Health and Welfare Plan" and is sometimes referred to in this document as the "Active Plan" (even though it also covers retirees who are not yet eligible for Medicare). The separate plan that applies only to Medicare-Eligible Retirees is the "UA Local 190 Medicare Retiree Health and Welfare Plan" and is sometimes referred to in this document as the "Medicare Plan." The Individual HRA Plan name is “UA Local 190 Individual HRA Plan.”

Plan Number

The UA Local 190 Health and Welfare Plan number is 501. The UA Local 190 Medicare Retiree Health and Welfare Plan number is 505. The Individual HRA Plan number is 504.

Employer Identification Number

The employer identification number of the Board of Trustees for the UA Local 190 Health and Welfare Plan is 38-6065578. The employer identification number of the Board of Trustees for the UA Local 190 Medicare Retiree Health and Welfare Plan is 47-4017809. The employer identification number of the Board of Trustees for the Individual HRA Fund is 26-0268950.

Type of Plan

The Plans are “employee welfare benefit plans” providing health and welfare benefits under the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan's Fiscal Year

The Plan fiscal years or Plan Years begin on June 1 and end on the subsequent May 31. However, see next subheading for claim year.

Claim Year

The calendar year (January 1 - December 31) is used for tabulating the accrual of Miscellaneous Benefits, which are limited to $1,800 for each calendar year, and Prescription Medicine Benefits, which are limited to $1,440 for each calendar year. Certain benefits under the Blue Cross Blue Shield administered Health Care Plan are limited based on the calendar year, such as preventive care, chiropractic visits, and skilled nursing care. The calendar year is also used for tabulating the limits on benefits under Delta Dental and the Employee Assistance Program.

The Cost of the Plan

Employer contributions are the primary source of financing for the benefits provided under this Fund and for the expenses of Fund operations. The rate of contribution is spelled out in the collective bargaining agreements negotiated by the Union with participating Employers. These contributions are held by the Trustees under the terms of the UA Local 190 Health and Welfare Trust and the UA Local 190 Individual HRA Trust and are invested to help defray the cost of benefits and administration.

When you are working the minimum number of hours required for coverage, no money is deducted from your paycheck to pay for these benefits. However, under the terms of the Plan, a Participant may make self-payments to retain eligibility if temporarily disabled or if the Participant does not work enough hours with a qualifying Employer to satisfy the eligibility provisions; in addition you have self-pay rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). 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 Spouse and Children.

Plan Sponsor and Administrator

This Plan is operated by a Joint Board of Trustees consisting of Trustees elected by the Union and appointed by the Associations. The Board of Trustees is the "plan sponsor" and the “plan administrator” of the Plan, as defined in the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees’ address for all purposes is the address of the Administrative Manager. See **Administrative Manager**, below.

Trustees elected by UA Local 190 - Plumbers/ Pipefitters/ Service Technicians/ Gas Distribution:

David Forbes
Kevin W. Groeb
Andrew Fielder
Douglas Mayher, Jr.

Alternate: Jeffrey M. Henry.

The principal place of business for these trustees is:

UA Local 190 - Plumbers/
Pipefitters/ Service Technicians/
Gas Distribution
7920 Jackson Road
Suite B
Ann Arbor, Michigan 48103

Trustees appointed by the Greater Michigan Plumbing & Mechanical Contractors Association, Inc. and their principal places of business:

Sandra L. Miller
Greater Michigan Plumbing & Mechanical Contractors Association, Inc.
58 Parkland Plaza, Suite 600
Ann Arbor, Michigan 48103

John T. Darr
John Darr Mechanical, Inc.
293 Dino Dr.
Ann Arbor, Michigan 48103

Michael D. Darr
Boone and Darr Incorporated
4465 South State
Ann Arbor, Michigan 48108

Jeremy Finn
John Darr Mechanical, Inc.
293 Dino Dr.
Ann Arbor, Michigan 48103

Agent For Legal Process

The agent for legal process for the Plan is the Plan's legal counsel, which is:

Ferguson Widmayer PC
538 North Division Street
Ann Arbor, Michigan 48104
ATTENTION: Warren J. Widmayer

Service of process also may be made on the Board of Trustees, which is also the Plan Administrator, at the following address:

UA Local 190 Health and Welfare Board of Trustees
c/o TIC International Corporation
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025

Other Rules of Administration

The Board of Trustees may adopt any rules for administration of the Plan it considers desirable, provided they do not conflict with the Plan, and may correct errors or defects, supply omissions and reconcile inconsistencies to the extent necessary to effectively administer the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and persons covered by this Plan may examine records pertaining directly to themselves.

The Board of Trustees, as Plan Administrator, has discretionary authority to determine the status and rights of Participants, Beneficiaries and other persons, to construe and interpret Plan terms, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, hire professionals and generally to do all other things needed to operate, manage and administer the Plan. The discretionary authority granted to the Plan Administrator is intended to be broad and entitles the Plan Administrator to deferential judicial review of the Plan Administrator's decisions pursuant to the U.S. Supreme Court's decision in Firestone Tire and Rubber Co. v. Bruch. This means that the Board of Trustees' actions, when performed as Plan Administrator, can be overturned by a court only if the action was arbitrary or capricious.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan.

Blue Cross Blue Shield administers medical Basic Benefits under the Plan, and it is the named fiduciary for Basic Benefits claims administration. Delta Dental USA administers Dental Benefits under the Plan, and it is the named fiduciary for Dental Benefits claims administration. Both the decisions made by Blue Cross Blue Shield and the decisions made by Delta Dental USA are subject to final appeal to the Board of Trustees as Plan Administrator. Certain other benefits of the Plan are provided pursuant to insurance policies purchased by the Plan Administrator from various insurance companies, or through contracts for services with other providers. These insurance companies and other providers are the named fiduciaries for claims administration of their respective benefits. The Plan Administrator retains all its other authority, including appeals of claim denials. Effective January 1, 2014, these claims and appeals procedures will be changing to include additional provisions for internal claims review and to add provisions for external claims review by an independent party for final review of claims.

Administrative Manager

The Board of Trustees retains all discretion and authority to make final decisions under the Plan and is considered the "Plan Administrator" under ERISA. However, daily operation of the Plan is carried out under a contract with an Administrative Manager. All correspondence to the Plan Administrator, Administrative Manager, or Board of Trustees should be sent to the Administrative Manager's office, which is the official address for the Plan.

The Administrative Manager for the Plan is:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025

EIN 13-2600875

Toll-free phone number: 1-888-390-PIPE (7473)

Certain documents are identified in this summary as available for review at the Union Business Office. The Union Business Office address is:

UA Local 190 - Plumbers/ Pipefitters/ Service Technicians/ Gas Distribution
7920 Jackson Road
Suite B
Ann Arbor, Michigan 48103

Fund Office

The Fund Office is the office of the Administrative Manager:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025

Fund Website

The Fund maintains a web site at which additional information, announcements, summary annual reports, and forms are available. The current version of this Summary Plan Description is also available there. The address of the Fund web site is http://www.ua190benefits.org.

Attorney for Fund

The attorney for the Fund is:

Ferguson Widmayer PC
Attn: Warren J. Widmayer
538 North Division
Ann Arbor, Michigan 48104

Collective Bargaining Agreements

The Health and Welfare Trust ("Fund") was established and is maintained under the terms of collective bargaining agreements. The agreements describe the conditions under which the participating Employers are required to contribute to the Fund and the rate of contributions. Upon written request, Participants and other persons covered by this Plan may examine the agreements at the offices of UA Local 190 or the Administrative Manager's office. Participants may request copies of the agreements from UA Local 190 - Plumbers/Pipefitters/Service Technicians/Gas Distribution, 7920 Jackson Road, Suite B, Ann Arbor, MI 48103.

Fund Medium for the Accumulation of Fund Assets

All contributions and investment earnings are accumulated by the Fund. Effective June 1, 2015, basic Life Insurance Death Benefit and Accidental Death and Dismemberment insurance is provided by the Metropolitan Life Insurance Company ("MetLife") in return for coverage premiums paid by the Fund. Effective December 1, 2015, optional supplemental group term life and accidental death and dismemberment insurance is provided by MetLife and optional supplemental individual whole life insurance is available through Texas Life Insurance Company. Employee Assistance Plan benefits are provided by Magellan HRSC, Inc. in return for coverage premiums paid by the Fund. These companies agree to provide all benefits in return for the premiums we pay, and the Fund is not at risk for any amounts other than the premiums for these benefits. The Fund is not at any risk for amounts paid for supplemental group term life and supplemental group accidental death and dismemberment insurance or supplemental individual whole life insurance since those premiums are paid solely by Members.

All other benefits are "self-funded," which means they are paid from the employer contributions and earnings on those contributions, which are held in the separate Trust Funds for the Plans. Although Blue Cross Blue Shield administers payment of Basic Benefits, the money for payment of claims comes from the Fund, not Blue Cross Blue Shield. Similarly, although Delta Dental administers payment of Dental Benefits, the money for payment of claims comes from the Fund, not Delta Dental.

Interpretation of Plan Provisions

No one has the authority to speak for the Trustees in explaining the eligibility provisions or benefits of the Plan, except the full Board of Trustees or the Plan's Administrative Manager to whom such authority has been delegated.

No plan provision or interpretation of the Plan is official unless it is issued in writing. No interpretation of the Plan can change the Plan's terms, and any interpretation of the Plan that is not consistent with the Plan is invalid. Interpretations of the Plan must be consistent with the Plan documents, which contain the official rules of the Plan.

Benefits Are Not Payable if Motor Vehicles Are Involved

The Fund does not provide coverage for any incident involving a motor vehicle, as defined in Section 9's Motor Vehicle Accident Injury Limitations and Exclusions.

Workers' Compensation Claims

Medical and hospital costs resulting from any injury/illness that is sustained during the course of any employment for wage or profit are **not** covered by the Plan. In certain instances, subject to review and approval by Fund Legal Counsel, an agreement may be signed that permits the Fund to pay for services and supplies provided as the result of the work-related injury/illness, subject to reimbursement whenever you collect benefits or are compensated by another source. If the claim is work-related, the Fund will require reimbursement from you or Workers' Compensation. This agreement protects the Fund during the period of time the Participant is pursuing claims through the Workers' Compensation system, against an Employer's liability carrier, through an Occupational Disease Fund, and/or against a manufacturer. Coverage is limited to the types of services and supplies normally covered by the Plan. Additional information and the actual agreement can be obtained from the Administrative Manager's Office. While you are on Workers' Compensation and unable to work, you may continue your Plan coverage for all other benefits under the self-pay rules.

Asbestos and Toxic Substance Exposure and Related Diseases

Any injury/illness that is the result of exposure to asbestos, chemical agents or other toxic substances is not normally covered by the Plan. In certain instances, subject to review and approval by Fund Legal Counsel, an agreement may be signed that permits the Fund to pay for services and supplies provided as the result of the exposure and/or related disease. If the claim is work-related, the Fund will require reimbursement from you or Workers' Compensation. This agreement protects the Fund during the period the person covered by this Plan is pursuing claim through the Workers' Compensation system, against an Employer's liability carrier, through an Occupational Disease Fund, and/or against a manufacturer. Coverage is limited to the types of services and supplies normally covered by the Plan. Additional information and the actual agreement can be obtained from the Administrative Manager's Office.

Payment of Benefits

Your coverage consists of services and supplies for which the Fund agrees to pay under the terms of your coverage documents. Payable services and supplies, as outlined in this Summary Plan Description ("SPD"), are called benefits.

Medical Necessity

A service that you receive from a medical provider must be medically necessary in order to be payable under your health care coverage. The guidelines for determining medical necessity are specified in Section 25, Definitions.

The Plan pays only for those services and supplies that are a medical necessity for the treatment of an injury/illness covered by the Plan, unless coverage is otherwise specifically provided by inclusion in the Plan. The Plan will not pay for any services or supplies for which the Participant is not required to pay.

Filing Limitation for Claiming Benefits

All claims for Basic Benefits must be submitted within 15 months from the date of service, except for hearing care claims, which must be submitted within 24 months from the date of service. Failure to file such claims within these time periods shall invalidate the claim unless it was not reasonably possible to file the claim within these time

frames. Other deadlines apply for filing claims for other benefits. **Effective upon distribution of the Benefit Advisor Card in August, 2012, all claims for reimbursements under Miscellaneous Benefits, Prescription Medicine Benefits, and the Individual HRA will be adjudicated through the use of a Benefit Advisor VISA card (referred to as a "Benefit Advisor Card" throughout this SPD)**. To be eligible for payment for services obtained from service providers that do not accept VISA, claims for reimbursement under Miscellaneous Benefits, Prescription Medicine Benefits and the Individual HRA must be submitted to the Fund Office by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued. Refer to Section 21, Filing Claims and Appeals, for more information about claim filing.

Your Coverage Identification Cards are Important

Once you enroll you will receive a Blue Cross Blue Shield identification card, a Delta Dental identification card, and a Benefit Advisor VISA Card. When you receive services, always present your card to the provider. You must present your Blue Cross Blue Shield identification card when filling prescriptions for the Plan to properly track expenses and provide you the maximum discounts available from Blue Cross Blue Shield. The numbers on your identification cards, especially the contract number, are very important in identifying your type of coverage. Be sure to sign the signature strip immediately.

You may request additional cards, without cost, for your eligible Children and Spouse. Remember, only you and your eligible Children and Spouse may use the card issued for your contract. Lending your card to anyone not eligible to use it is illegal.

Make sure you carry the most current card. Using outdated cards delays payment of claims.

If your card is lost or stolen, you can still receive services, but report the loss of your card immediately to the Administrative Manager or to a Blue Cross Blue Shield or Delta Dental representative. You will be charged a $10.00 fee if you need a replacement Benefit Advisor Card. Your customer service phone numbers and addresses are listed at the end of this SPD.

Customer Service

If you have questions about your Blue Cross Blue Shield coverage, please contact a Blue Cross Blue Shield customer service representative (see the end of this SPD for phone numbers and address).

To help the customer service representative service you better, here are some tips to remember:

- Blue Cross Blue Shield needs to know your contract number to help you with your inquiry. Your contract number can be found on your Blue Cross Blue Shield ID card.
- In addition to your contract number, Blue Cross Blue Shield would like to have a daytime telephone number where you can be reached, if possible.
- If you are questioning a service, Blue Cross Blue Shield will need the Patient's name, name of the provider (i.e., Hospital, doctor, lab, etc.), date of service, type of service and charge(s).
- When sending bills, forms or other papers, please make copies of them before you send them. Send the originals to Blue Cross Blue Shield and keep the copies for your records.
- When visiting one of Blue Cross Blue Shield's customer service offices, please bring a copy of any bills, forms or other material related to your inquiry.

If you have questions about your Delta Dental coverage, please contact a Delta Dental customer service representative (see **Section 23** of this SPD for contact information).

Explanation of Benefits

An Explanation of Benefits (EOB) will be sent to you after you receive services and Blue Cross Blue Shield or Delta Dental has processed your claim. The EOB shows you what services have been paid by Blue Cross Blue Shield or Delta Dental and what, if anything, you owe. It is not a bill.

If your claim is denied, the EOB will explain why the service or part of the charge was not covered. Please check this form carefully to make sure that you received the services listed. It is very important that you notify Blue Cross Blue Shield or Delta Dental if you did not receive the services or if there are any discrepancies.

Health Care Tips: How You Can Help Reduce Costs

The cost of health care affects everyone--even those with health care coverage. That's why it is so important that each of us takes an active part in controlling costs and keeping health care affordable for everyone.

Here are some important tips to remember:

1. **Use Participating Providers.**
Participating providers have chosen to work closely with Blue Cross Blue Shield and Delta Dental to help hold down rising medical costs. When you choose a participating provider, you limit your own out-of-pocket expenses and support our cost containment efforts.

2. **Select a personal Physician.**
It's important to have one physician that you see on a regular basis. Most people use either their family practitioner or an internist as their personal physician or "family doctor." Let your physician get to know you, your medical history and lifestyle. Your personal physician can then take care of you for regular checkups as well as referring you to specialists or coordinating your hospital care when it is necessary. Be sure to select a physician who makes you feel comfortable and whose specialization meets most of your day-to-day health care needs.

3. **Understand your Health Care Benefits.**
Use this SPD and the detailed Benefit Schedule, available upon request, as guides to know exactly what services are covered before you need to use them. Learn the meaning of terms such as co-payment and lifetime dollar maximum.

Become familiar with your coverage before a medical crisis occurs.

4. **Ask questions.**
Feel free to ask your physician questions. It's important to know how much office visits cost, if recommended tests are necessary, or if a prescribed medication has possible side effects.

If your physician recommends hospitalization or surgery, ask these questions: Is hospitalization necessary? Can tests be done before the hospital admission? Can surgery be done on the day of admission, or on an outpatient basis?

Always insist on quality care. Asking questions makes you aware of all the options available to you. Discuss your options with your physician so you can make an informed decision.

5. **Use emergency rooms for emergencies only.**
Unless your problem is a true emergency, it is less costly for you to visit an urgent care clinic or physician's office than to seek treatment in an emergency room. Because emergency rooms must have specialized staff and equipment to handle true emergencies, they are one of the most expensive places to receive medical care. The emergency room is the best place to go when you are faced with a life-threatening emergency or Accidental Injury, but when the problem isn't as serious, visit a clinic or your doctor's office. <u>If you go to an emergency room and it is not an emergency, it will not be paid for</u>.

6. **Use your Benefits efficiently.**
The **best** health care isn't always the most **expensive** care. That's why you need to consider the value of "managed care" or "health care management." For example, when you need medical assistance, you may want to ask your doctor about home health care instead of costly hospitalization. Home health care is an example of efficient use of your benefits because you receive the medical care you need in the less expensive and familiar surroundings of your own home.

7. **Stay healthy.**
The best way to protect your health is to maintain a healthy lifestyle. Use good sense in maintaining a balanced diet, exercising regularly, wearing your seatbelt and avoiding the use of tobacco and the abuse of alcohol. Pay attention to the warning signs your body gives you. When you follow good health rules, you avoid habits and activities that put you at risk for disease and injury.

As an added benefit, Blue Cross Blue Shield has teamed up with Weight Watchers®. As a Blue Cross Blue Shield member, you receive a special discounted membership in community Weight Watchers' meetings near you. Just show your Blue Cross Blue Shield ID card.

8. **Look over your medical bills.**
Doctors' offices and hospitals can make mistakes, so it's smart to look at your bills closely. Make sure you aren't billed for services you didn't receive. If you do find an error, let your physician or hospital know about it right away. If you don't receive quick satisfaction, call the Administrative Manager's Office.

9. **Help prevent fraud.**
Each year, health care fraud costs employers and employees $100 billion nationwide. That's why it's so important to check your bills and Explanation of Benefits notices to make sure you received the services listed. Never let someone else use your Blue Cross Blue Shield ID card. If you suspect fraud, please call the Blue Cross Blue Shield Anti-Fraud Hotline. The phone number within Michigan is 1-800-482-3787. If you are outside Michigan call the main switchboard at 313-225-8100 and ask for the fraud unit. All calls in Michigan are toll free, and you do not have to identify yourself. Your call may help Blue Cross Blue Shield recover funds.

Plan Changes

The Board of Trustees reserves the right to amend or modify the Plan and/or terminate the Plan or individual coverages or programs under the Plan at any time for any reason. The Trustees make amendments or modifications to the Plan by a resolution adopted in accordance with the established procedures of the Trustees and recorded in the form of a written amendment or meeting minutes, or by such person(s) as the Trustees may designate. Any such amendment shall be effective as of such date as the Trustees or their designee shall determine and may be passed with retroactive effect to the extent permitted by ERISA and the Internal Revenue Code. If there are assets in the Plan at the time the Plan is terminated, they will either be used to pay benefits or expenses of Plan administration until there are no remaining assets, or they will be transferred to another benefit plan benefiting substantially the same Members as were benefited by this Plan. No such assets will be returned to the Employers.

A summary describing any amendment to the Plan will be distributed to all Plan Participants. Such a summary may be in the form of revised pages of this SPD. If you receive revised pages, follow the instructions you receive for removing and replacing pages of this booklet, so you always have the most current version.

Forms and Agreements Necessary Under the Plan

Your Enrollment Form must be executed before the date you become eligible to participate in the Plan. If this is not done, eligibility will not begin until the Administrative Manager receives the Enrollment Form.

You must update your Enrollment Form to reflect changes in Spouse or Children within 30 days of the change. If you do not do so within the required time, coverage may be delayed until the first day of the month after the Enrollment Form is submitted and approved by the Fund Office.

The Administrative Manager has the right and authority to establish any forms or agreements it finds necessary to administer the Plan's day-to-day operation. Any such form may contain reasonable procedures, deadlines and other requirements created by the Administrative Manager to efficiently operate the Plan. Further, the Administrative Manager has the authority to enforce the use of these forms or agreements by Participants.

Other Important Administrative Provisions

Following are some other important administrative provisions:

Waiver. Failure by the Plan or Plan Administrator to insist upon compliance with any provision of the Plan at any time or under any set of circumstances does not waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan is valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

Facility of Payment. When any person entitled to benefits under the Plan is under legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the benefits that would otherwise be payable to such person will be paid to such person's legal representative for the person's benefit or be applied for the benefit of such person in any other manner that the Plan Administrator may determine. Such payment of the benefits shall completely discharge the liability of the Plan and Plan Administrator for such benefits.

Addresses, Notice, Waiver of Notice. Each Participant must file with the Administrative Manager in writing his or her post office address and any change of post office address. Any communication, statement or notice addressed to the Participant (or the Participant's Beneficiaries) at the last post office address as filed with the Administrative Manager will be binding upon the Participant (and the Participant's Beneficiaries) for all purposes of the Plan, and neither the Board of Trustees nor the Administrative Manager shall be obliged to search for or ascertain the whereabouts of any such person. The person entitled to notice may waive any notice required under the Plan.

Designation of Administrative Authority. The Plan Administrator may appoint one or more persons to assist in the administration of the Plan. Any person, including Participants, will be eligible for such appointment to assist in the administration.

Services of the Plan. The Plan Administrator may contract for legal, actuarial, investment, advisory, medical, accounting, clerical and other services to carry out the Plan.

Transfer of Benefits. No benefit under the Plan may be voluntarily or involuntarily assigned or transferred to someone else unless otherwise provided for by the Plan.

Liability of Administrative Personnel. Neither you as a Participant, your Employer, a sponsoring Union, contributing Employer, nor any of their respective Associations, officers, shareholders, directors, agents or representatives shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the willful misconduct of the party to be charged or is due to the failure of the party to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims.

Status of Benefits. The Trustees believe that the Plan is in compliance with the Internal Revenue Code and that it provides certain benefits to Participants. The Plan has not been submitted to the Internal Revenue Service for approval and, thus, there can be and is no assurance that intended benefits will be available on a tax-free basis as intended. By accepting benefits under the Plan, you as a Participant agree to be liable for any tax that may be imposed with respect to those benefits, plus any penalty and interest that may be imposed.

No Right to Anticipate Benefit. No Participant, other covered person, or Beneficiary shall have any right, title or interest in any benefit provided under the Plan prior to the payment thereof to such person, nor shall benefits be subject to garnishment or attachment, but may be subject to an authorized subrogation or assignment.

Litigation. In any action or proceeding regarding the administration of the Plan, Participants or former Participants, their Beneficiaries, or any other person having or claiming to have an interest in the Plan shall not be necessary parties and shall not be entitled to any notice of process. Any final judgment which is not appealed or appealable shall be binding and conclusive on the parties hereto and all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Plan Administrator, the Administrative Manager or an organization providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person, or if a legal action arises because of conflicting benefit claims, the cost to the Plan Administrator, the Administrative Manager or such other organization defending the action will be reimbursed by the Fund. No Participant, Beneficiary, or any other person or entity claiming to have an interest in the Plan may sue the Plan Trustees or any other party related to Plan administration unless and until that person or organization has completely exhausted the claims and appeals procedures of the Plan. You have a two year period following exhaustion of the claims and appeals procedures of the Plan in which to file a legal action against the Plan Administrator, the Administrative Manager or any organization providing benefits under the Plan, after which all claims will be barred.

Mistake of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

No Vested Interest. Except for the right to receive any benefit payable under the Plan, no person has any right, title or interest in or to the assets of the Fund because of the Plan.

Governing Law. The Plan shall be interpreted under federal law, including ERISA, and under the laws of the State of Michigan to the extent not preempted.

Severability. If any provision of the Plan is held invalid or unenforceable, the invalidity or unenforceability will not affect any other provision, and the Plan will be construed and enforced as if the invalid or unenforceable provision had not been included.

Headings and Captions. The headings and captions set forth in this document are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Participation in the Plan Creates No Obligation For Employment

The Plan shall not be deemed to constitute a contract between you and your Employer nor to be consideration or an inducement for your employment. Nothing contained in the Plan creates new employment rights or expands your rights beyond the provisions of the collective bargaining agreement between the Union and the Employers.

Administering Qualified Medical Child Support Orders

The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of Section 609 of ERISA. A medical child support order is any judgment, decree or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction or issued by an agency (in Michigan, the Friend of the Court) pursuant to an administrative process established under State law and which has the force and effect of law under applicable State law which (1) relates to the provision of child support with respect to the child of a Participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan, or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits payable with respect to a Participant or beneficiary under a group health plan. For purposes of this section, an "alternate recipient" shall mean any child of a Participant who is recognized by a qualified medical child support order as having the right to enrollment under a group health plan with respect to such Participant.

Any such qualified medical child support order must clearly specify the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order, a reasonable description of the type of coverage to be provided under the group health plan to each such alternate recipient or the manner in which such type of coverage is to be determined, the period to which such order applies, and each plan to which such order applies.

Any such qualified medical child support order shall not require the Plan to provide any type of benefit or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of the law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the qualified status of medical child support orders. If the Plan Administrator determines that the requested health care coverage is not available, and it received Notice of the order pursuant to the National Medical Support Notice Procedure, the Plan Administrator will complete "Part A-Employer's Response" and forward it to the issuing agency. Otherwise, within a reasonable period of time after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. In the case of orders issued under the National Medical Support Notice Procedure, the Plan Administrator will do so within 40 business days of the date of the Notice, or sooner, if reasonable, and will complete "Part B-Plan Administrator Response" and forward it to the issuing agency. The Plan Administrator will notify the Member and each alternate recipient, the custodial parent (if other than the Participant) and the issuing agency, if applicable if it determines that the order or Notice is not qualified and will provide specific reasons for the decision. If the Participant or any affected alternate recipient disagrees with the determination of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Upon determination that the Notice or order is qualified, the Plan Administrator shall notify the Participant, each alternate recipient, the custodial parent (if other than the Participant), and the issuing agency (if applicable) that coverage is or will become available, the effective date of such coverage or if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision of the State substituted for the name of the child) to activate the coverage. In addition, the Plan Administrator will furnish the custodial parent a description of the coverage available, including, if not already provided, a copy of this SPD and any forms, documents or information necessary to activate the coverage.

If the Plan Administrator determines that the order or Notice is qualified, the plan will follow the order unless or until compliance with the order would violate legal restrictions on wage withholding (if any), the Participant is no longer employed and/or eligible for the ordered coverage, it receives satisfactory written evidence that the order is no longer in effect, the alternate recipients are or will be enrolled in comparable health coverage effective no later than the date of disenrollment in this Plan, family health coverage for all employees has been eliminated, any available continuation coverage is not elected, or the period of any continuation coverage expires.

The Plan Administrator will notify the appropriate employer of any qualified order or Notice for wage withholding (if any) purposes.

Alternate recipients of a qualified medical child support order shall be treated as Children under the Plan for all purposes of ERISA.

Payments under this Plan under a medical child support order described in this section as reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian. If there has been a valid assignment of benefits to the state under Medicaid under applicable state law, payment will be made to the state.

Coordination of Benefits (COB)

All benefits except for Life Insurance Death Benefits and Accidental Death and Dismemberment Benefits are subject to Coordination of Benefit provisions, which help achieve full payment but prevent duplicate payment. Refer to Section 22, Coordination of Benefits and Subrogation, for more information.

Trustee Authorities

The Trustees have the authority to interpret the specific provisions of this Plan.

The Trustees give the Plan's Administrative Manager the discretionary power and authority to construe terms of the Plan and determine eligibility for benefits, subject to the right of final appeal to the Board of Trustees pursuant to the procedures for claims and appeals contained in this SPD. The Administrative Manager's decisions in these discretionary matters are to be given due deference.

The Trustees shall have the right and opportunity to have the person whose injury or sickness is the basis of the claim examined by a licensed physician when, in their opinion, it is necessary to determine the validity of the claim.

The Trustees have the right and authority to:

- Amend the Plan, including eligibility provisions, modify the schedule of benefits, purchase or terminate insurance contracts, enter into provider arrangements, delegate responsibility for benefit determination, establish cost containment programs, and engage individuals or firms to assist in the management of the Fund at any time they deem necessary.

- Refuse payment of any claim they feel may be fraudulent or any claim that is not satisfactorily authenticated or documented.

- Assess penalties for failure to provide correct and accurate information for the processing of benefit payments when such failure results in the need to recalculate claim payments or recover overpayments.

- Assess penalties if checks that are submitted for payments are returned due to insufficient funds.

- Refuse payment of benefits to any covered person related to a Participant when an existing overpayment of benefits has not been repaid.

Participant Rights

In addition to rights specified elsewhere in this SPD, the Participant has the right to select his or her own physician, surgeon and provider of service, subject to the benefit limitations that may exist if a participating provider also provides the same service or supply. A physician-patient relationship shall be maintained, and a signed authorization for the release of information is required for insurance company and Trustee access to medical records.

The Participant has the right to designate a Beneficiary. The Participant shall automatically be deemed to be the Beneficiary for the payment of any benefits of an eligible Spouse or Child, and no eligible Spouse or Child shall be entitled to designate a Beneficiary.

Also, as a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants and other persons covered by this Plan shall be entitled to:

- Examine, without charge, at the Administrative Manager's Office all Plan documents, including the Plan, the Trust, collective bargaining agreements, insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Manager. The Administrative Manager may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of the summary annual report upon request.

- Obtain from the Administrative Manager, without charge, a copy of the Plan's procedures regarding Qualified Medical Child Support Order (QMSCO) determinations. Issues involving these orders may be resolved in Federal court.

- Continue health care coverage for yourself, Spouse or Children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse and Children may have to pay for such coverage. Review this summary plan description (see **Section 20, COBRA Continuation of Health Coverage**) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- The reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) (unless you are under the age of 19) after your enrollment date in your coverage. The requirement to provide certificates of creditable coverage applies through December 31, 2014. (See **Section 15, Pre-Existing Conditions**)

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan Participants and beneficiaries.

No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. You may also file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Manager.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Administrative Manager's office.

If you have any questions about this Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Procedures for Recovery of Overpayment

When it is discovered that a claim has been overpaid, the Participant will be notified of the overpayment and requested to refund the overpayment amount.

In the event the check was recently sent directly to the provider, an attempt will first be made to recover the check, uncashed, from the provider or to obtain a refund from said provider.

Any reasonable procedure designed to expedite recovery of overpayments and minimize the risk of loss to the Fund may be employed after the initial notice of overpayment has been given to the provider or Participant. Absent a determination by the Trustees or Administrative Manager that an expedited procedure should be followed to minimize risk of loss to the Fund, the following procedure shall be followed:

> If neither the provider nor the Participant returns the check or refunds the overpaid amount, a second notification will be sent after 30 days to the Participant. If after an additional 30 day period the overpayment still exists, any benefits that would otherwise have been payable for charges incurred by the Participant or any covered Child or Spouse will be applied towards the overpayment until the entire overpaid amount is recovered. If a provider who is overpaid refuses to return the overpayment, the Trustees may initiate or request that Blue Cross Blue Shield or Delta Dental initiate recovery in the form of offsets of any other amounts owed to the provider, until the overpayment is recovered. The Trustees may, in their discretion, either seek reimbursement directly from such Participant with respect to such expenses or request a Participant's Employer to withhold such amounts proportionately from such Participant's future wages and turn over such amounts to the Plan until the amount owed to the Plan has been recovered. The provider and the Participant will be notified in writing that this action has been taken.

Fund Legal Counsel may become involved in collection attempts of overpaid claims at any point in this process. Fund Legal Counsel will be kept informed of any payments received or claims applied to the overpayment.

All notification letters sent to the Participant will include the specific amount of the overpayment, the reason for overpayment and amount of reprocessing fee due, if applicable.

Participant Responsibilities

While the Trustees take every reasonable effort to make certain that Participants receive all benefits to which they are entitled, the ultimate responsibility rests with the Participants. Certain things must be done to protect and assure receipt of benefits. A Participant:

- Must complete the Coordination of Benefits questionnaire once each year and file it with the Administrative Manager's Office promptly.

- Must notify the Administrative Manager's Office anytime the Participant has a change of address, change in marital status, a death of a family member of a covered person, a change in Spouse or Children, or a change in other health care coverage.

- Should complete a Participant Data Form to designate or change his or her Beneficiary and file it with the Administrative Manager's Office.

- Is expected to familiarize himself or herself with the eligibility and benefit provisions of the Plan.

- Must make any required self-contributions or self-payments on time and in the correct amounts. To protect the Fund from abuse, the Trustees cannot accept self-payments or self-contributions after claims have been incurred.

- Is expected to fully cooperate, submit to medical examinations as often as is reasonably necessary, and release medical records to the Fund. Failure to cooperate shall constitute a basis for denying a claim.

- Must provide all information requested on the claim form and any additional information that may be requested by the Administrative Manager's Office. This will avoid unnecessary delays in processing the Claim.

- Must file all Basic Benefit claims within 15 months from the date services or supplies are provided, except for hearing claims, which must be filed within 24 months of receiving service, and must file all Miscellaneous Benefit, Prescription Medicine Benefit, and Individual Health Reimbursement Account Benefit claims by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued.

- Is expected to cooperate with the Administrative Manager's Office in the investigation of any fraudulent claim or any claim that is not satisfactorily documented.

- Is urged to obtain the proper motor vehicular coverage to protect the Participant and the Participant's Spouse and Children in the event of a motor vehicular related accident or incident, because no Basic Benefits are paid by the Fund for injuries or claims arising from motor vehicle accidents.

- Should use the Blue Cross Blue Shield, Delta Dental and Benefit Advisor cards that are available from the Administrative Manager's Office or at the Participant's local union whenever treatment is provided.

- Is expected to provide the Administrative Manager's Office with a copy of a marriage license, complete copies of all divorce papers, copies of birth certificates for Spouse and Children and appropriate documents as proof of continued eligibility of Spouse and Children.

- Is expected to participate in any hospital bill review program by completing appropriate forms and questionnaires regarding inpatient confinements.

- Is expected to participate in all cost containment programs adopted by the Fund.

Privacy of Protected Health Information

Information gathered by the health and dental portions of the Plan (all benefits other than Loss of Time, Life Insurance Death Benefit, and Accidental Death and Dismemberment Benefits) is protected by law from unnecessary disclosure. Specifically, health information that is individually identifiable (information that includes items that can be used to determine who the information relates to) is "protected information." The Plan may share protected health information with the Joint Board of Trustees of the UA Local 190 Health and Welfare Plan, which is the Plan Sponsor, under the circumstances stated in this section.

There are three circumstances under which the Plan may disclose protected health information to the Plan Sponsor:

- First, the Plan may inform the Plan Sponsor whether a person is enrolled in the Plan.

- Second, the Plan may disclose "summary health information" to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims with all identifying information except the five-digit zip code removed.

- Third, the Plan may disclose protected health information to the Plan Sponsor for Plan administrative purposes. The Trustees, who as a group are considered the Plan Sponsor, are also considered, as a group, to be the Plan Administrator, and have the ultimate responsibility for operating the Plan. The Trustees fulfill this responsibility by carefully selecting professional administrators to handle most of these functions, such as enrolling Members, processing claims filed by health care providers and Members, and otherwise operating the Plan according to its provisions. The Trustees directly perform limited administrative functions necessary for the management and

operation of the Plan - particularly Plan language interpretation in specific cases, claim reviews and appeals of contested claims.

The Plan Sponsor's use and disclosure of protected health information is subject to the following restrictions:

- The Plan Sponsor will only use or disclose protected health information for Plan administrative purposes, as required by law, or as permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

- If the Plan Sponsor discloses any protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep protected health information private as required by the HIPAA regulations.

- The Plan Sponsor will not use or disclose protected health information to anyone for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor. This means that individuals will be required to separately provide protected health information to other plans if they wish to claim other benefits that are not part of the health plan, such as Loss of Time Benefits or Disability Pension Benefits, even though the health information is available under the Health or Dental Plans. The Trustees will disregard any protected health information knowledge obtained through Health Care Plan activity when making decisions under any non-Health Care Plan.

- The Plan Sponsor will promptly report to the Plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures described in this section.

- The Plan Sponsor will allow Participants or the Plan to inspect and copy any protected health information that is in the Plan Sponsor's custody and control, to the extent permitted or required by the HIPAA Regulations.

- The Plan Sponsor will amend, or allow the Plan to amend, any portion of protected health information to the extent permitted or required under the HIPAA Regulations.

- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). Participants will have a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.

- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of protected health information available to the Plan and to the U.S. Department of Health and Human Services.

- The Plan Sponsor will, if feasible, return or destroy all of protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any Business Associate when the Plan Sponsor no longer needs protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The members of the Joint Board of Trustees are the only individuals under the direct control of the Plan Sponsor who may be given access to protected health information for the purposes set forth in this document. If any Trustee uses or discloses protected health information in violation of the rules that are set out in this summary, the Trustee will be subject to disciplinary action and sanctions.

If a Trustee uses or discloses protected health information in violation of the rules that are set out in this section, the Joint Board of Trustees may discipline the Trustee. Discipline may include any action determined by the Joint Board of Trustees to be reasonably expected to eliminate the possibility of further violations, including, for example, reprimand, imposition of special security measures with respect to the violating Trustee, or removal from the Joint Board of Trustees by a vote of a majority of the Trustees serving on the Board at the time of the vote, in the sole

discretion of the Trustees, and the Trust is hereby amended to the extent necessary to allow such removal under these circumstances. If a Trustee is so removed, the Union or Association that appointed the removed Trustee will appoint a replacement.

If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to any Participant.

The Joint Board of Trustees also contracts with various consultants, advisors, and third-party administrators to provide for operation of the Plan ("Business Associates"). The Trustees will require all Business Associates to contractually agree to protect all protected health information provided to them as required by the HIPAA regulations.

The Joint Board of Trustees' Oversight Committee is also the HIPAA Committee. That committee currently consists of the following individuals:

Kevin Groeb, Trustee
Sandra L. Miller, Trustee

The HIPAA Committee is authorized to formulate privacy practices, policies and procedures, draft, review and approve Business Associate agreements, and draft, review and approve privacy notices to be provided to Plan Participants. The HIPAA Committee also is required to monitor the Plan's compliance with the HIPAA regulations. The HIPAA Committee may employ and consult with legal counsel, who may be the legal counsel for the Plan, to obtain assistance and advice in carrying out these duties.

The Joint Board of Trustees also has appointed James Schreiber of the Administrative Manager's office as the Plan's Health Care Privacy Official to provide oversight of compliance with the policies and procedures related to the protection of protected health information and federal and state regulations related to Participant privacy.

See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA. A copy of the notice is available upon request from:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025
(888) 390-7473

SECTION 2

ELIGIBILITY: ACTIVELY AT WORK MEMBERS

Initial Eligibility Provisions (Effective For Members Not Eligible As Of April 1, 2007 Under 120-Hour Rule)

How do I become eligible for these Benefits as a Member Actively at Work in the Local 190 jurisdiction?

You will become eligible to be covered by the Plan on the first day of the month following completion of 520 hours of covered employment within a 12-month period. This is your "eligibility date." For example, if you start working in June, and by August you have completed a total of 520 hours of covered employment, you will be eligible for coverage starting September 1, and September 1 is your "eligibility date."

The period for determining eligibility starts with your first month of work, and rolls forward until you have a consecutive 12-month period, or less, in which you are credited with 520 hours. (Covered employment means employment with an Employer bound by the collective bargaining agreement.)

If you work in a classification that is subject to a probationary period, your "eligibility date" is the first day of the month following completion of 120 hours of covered employment within a 12-month period that starts after the month your probationary period ends.

If you return to work following retirement and you are a Medicare-Eligible Retiree, your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan terminates and you become covered under the UA Local 190 Health and Welfare Plan immediately upon your return to work, without having to complete a new period of 520 hours of covered employment. Once you stop working, your coverage under the UA Local 190 Health and Welfare Plan terminates and your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan resumes.

When does my coverage actually begin?

You must complete a Member Application form and have it approved by the Administrative Manager before your coverage is effective. The application deadline is the last day of the month after the month of your eligibility date. So, in the example above, since your eligibility date is September 1, your Member Application form must be submitted and approved by the Administrative Manager by October 31. Coverage will be made effective as of your eligibility date (retroactive) only if you file your Member Application by the application deadline and the Administrative Manager approves the Member Application. If you do not file the application by the application deadline, coverage will not become effective until the first day of the month after the date on which your Member Application is filed and approved by the Administrative Manager.

What requirements must I meet to stay covered after my coverage has begun?

Meeting the original eligibility requirements results in coverage for the month beginning with your eligibility date and the following month. (In the example above, this would be September and October.)

After the first two months of coverage, you must have at least 100 hours of covered employment in an eligibility month (commonly referred to as the "work month") in order to be covered for the coverage month linked to that eligibility month. The eligibility month is the second month before each coverage month. Your initial eligibility month is the month containing the eligibility date, and the first coverage month subject to the 100-hour rule is the second month after that month. (In the example above, the first coverage month is September, the month containing the eligibility date. The first coverage month subject to the 100-hour rule is November, the second month after September.)

This table shows the months that determine eligibility for each coverage month under the 100-hour rule:

Hours Worked in this month ("Eligibility Month")	Control Coverage for this month ("Coverage Month")
November	January
December	February
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December

What if I don't work 100 hours in an eligibility month?

If you don't qualify for coverage for a particular coverage month because your hours were too low, you must make a payment under one of the self-payment programs described in this booklet and make the required self-payments on time. See **Eligibility During Periods of Unemployment (Self-Payment Provisions)**, below.

For a special exception to the 100 hours per month rule, see **One-Time Exception to 100-Hour Requirement**, below.

Non-Bargaining Unit Employees

Can Non-Bargaining Unit Employees be Participants in the Plan?

Non-Bargaining Unit Employees of an Employer may become Participants in the Plan if their Employer elects in writing that all of its Non-Bargaining Unit Employees shall become Participants in the Plan, and the Employer pays to the Trustees the same hourly rate with respect to its Non-Bargaining Unit Employees as it is obligated to pay from time to time with respect to its employees who are Members. Unless otherwise specifically provided in the Plan, Non-Bargaining Unit Employees who are Participants are subject to the same provisions of the Plan applicable to Members, except that Non-Bargaining Unit Employees are not eligible to continue under any self-pay arrangement except COBRA Continuation of Coverage. Non-Bargaining Unit Employees become eligible to be Participants on the first day of the month following completion of five consecutive months of service with their Employer or completion of five consecutive months of service after the Employer's election of coverage, whichever is later. Payment of contributions must be made during these five months. Participation shall be pursuant to a written agreement with the Trustees, which shall provide for minimum payments covering 140 hours per month.

Continuation of Eligibility

Once eligible, how do I continue to be eligible?

To continue eligibility you must work 100 hours per month or, if applicable, make a self-payments in the amount set by the Trustees. You have no coverage for medical expenses incurred after the end of the month that follows the month in which you work less than 100 hours in covered employment, unless you continue on a self-payment basis as described below. For example, if you work 100 hours in November and December but only 95 hours in January, your covered medical expenses incurred in January and February will be paid by the Plan, but expenses incurred after February will not be covered unless you reinstate coverage under the self-pay rules.

If you lose eligibility because of termination of employment or reduction of hours, you may be entitled to continuation coverage on a self-payment basis. See **Eligibility During Periods of Unemployment (Self-Payment Provisions)**, below.

One-Time Exception to 100-Hour Rule

What if I take a vacation some month and work less than 100 hours? Is there an exception to the requirement that I work 100 hours per month to remain eligible?

The Trustees recognize that Members who take a vacation from work may have a month in which they work less than 100 hours during the month when the Member takes an extended vacation. To accommodate such situations, a Member can have one month per Plan Year in which the 100-hour requirement is reduced to 60 hours due to failure to achieve the 100 hours due to vacation. To remain eligible without making self-payments in a month in which you work more than 60 hours but less than 100 hours due to vacation, you must notify the Fund Office in writing that you are electing to use your 60-hour month. Please do this as soon as you know that you will have less than 100 hours in a month, so the Fund Office does not demand that you self-pay for that month.

Termination and Reinstatement of Coverage

If my coverage is terminated, how do I again become eligible?

If your coverage is terminated (for example, you work less than 100 hours in a month and do not make the required self-payments to remain eligible), you must complete 520 hours of employment within a 12-month period after termination to again become eligible. If this is done within the first 12 months after your coverage terminates, you will not be required to file a new application, and your coverage will again commence as of the first day of the month following completion of the 520 hours. If your period of termination of coverage is more than 12 months before the 520-hour rule is fulfilled, then you must also fill out and submit a new application form when you complete the 520 hours.

You will not be covered for treatment incurred during the period of termination.

Eligibility of Spouse and Children of Actively at Work Participants

Are my Spouse and Children eligible?

If you are an Actively at Work Participant your Spouse and Children are eligible whenever you are eligible, provided the Children meet the definition of eligible Children under the Plan. See the definition of Children in **Section 25, Definitions**. Eligible covered family members include:

- Your legal Spouse.
- Through December 31, 2013, your Child or Children who are not eligible for other employment-based health coverage (other than through a parent), until their 26th birthday. Effective January 1, 2014, your Child or Children, until their 26th birthday, even if they are eligible for other employment-based coverage.
- In some cases, your Child who is disabled (see below).

Are my stepchildren eligible?

A child of your Spouse is eligible only 1) during the period you are legally married to your Spouse 2) until the child has not attained his or her 26th birthday; and 3) as long as he or she is not eligible for other employment-based coverage, other than through a parent.

When does coverage for my eligible Spouse and Children begin?

Coverage for your eligible Spouse and Children becomes effective when your coverage becomes effective if you include them in your Member Application Form at the time you apply for coverage. If you are Actively at Work and you wish to add a Spouse or Child who was not included in your original Member Application, see "Changes in Your Family and Special Enrollment Rights " in Section 9.

Eligibility of Natural and Adopted Children Who Are Disabled

What if my child is disabled?

Your Child or Children who are incapable of self-sustaining employment by reason of a mental or physical handicap may be eligible to remain covered under the Plan beyond age 26. This continued coverage is only available if all of the following conditions are satisfied: 1) the Child became incapacitated before the end of the year in which he or she reached age 26; 2) the Child is principally dependent on you for support and maintenance; and 3) upon request, you provide satisfactory documentation of the existence of the mental or physical handicap at no expense to the Fund (unless the expense is pre-approved by the Fund), no later than January 31 of the year after the year the Child attains age 26 for coverage to continue. Such documentation may include school records/reports, physician's statements, court documents or determination by the Social Security Administration. Coverage will continue as long as the Child is chiefly dependent upon you for support and maintenance due to the disabling condition.

Foster children are not eligible as Children.

Continuation Coverage for Spouse and Children

Can my Spouse and Children who become ineligible continue coverage?

Under certain circumstances, your Spouse and Children who become ineligible may be entitled to continue coverage on a self-pay basis either under a Self-Payment Program of the Fund, or under COBRA. See the remainder of this Section and **Section 20** for more information on **COBRA Continuation of Health Coverage**, and see **Section 19, Self Pay Rules**.

Eligibility During Periods of Unemployment (Self-Payment Provisions)

What is my eligibility if I am not disabled, but I become unemployed or my hours fall below 100 in a month?

If you are an eligible Participant who would otherwise lose your eligibility because you do not have Employer contributions for a sufficient number of hours remitted to the Fund on your behalf to meet the continuing eligibility requirements, you may continue eligibility by means of a Self-Payment Program provided by the Fund, through a federal law called COBRA.

Lower-Cost Self-Payment Program. The Fund's actuary determines the full-cost COBRA self-payment rate based on the average cost of coverage over the preceding year. But if you are an Actively-At-Work Member whose hours fall below 100 in a month, you may be eligible for a reduced-rate COBRA self-payment program if you meet the reduced-rate program requirements. See ***"How do I qualify for the special lower-cost Self-Payment Program*** below. Reduced-rate self-payments are made for up to 12 months out of any 18-month period at the reduced rate. See Section 19, "Self Pay Rules," for the current reduced rate.

Full-Cost Self-Payment Program ("Full COBRA Rate"). If you do not meet the reduced-rate Self-Payment Program eligibility requirements or have used up the full 12 months under that program, you may continue your coverage under the Fund under full-cost COBRA continuation of health coverage Self-Payment Program until your total combined months of reduced-payment Self-Payment coverage and COBRA Continuation Self-Payment coverage equal 18 months (for example, up to 6 additional months after the first 12 months at the lower Self-Payment rate, or the full18-month period if you did not qualify for the reduced-rate self payments). Generally, the reduced-rate self-payments period and the full –cost COBRA continuation period together cannot exceed 18 months (or as otherwise provided pursuant to the "COBRA" statute) and that 18-month period is the total required continuation period as provided by COBRA for a reduction in hours or termination of employment. Your total combined months of continuation coverage may be extended to up to 29 months if you are disabled within 60 days of the start of Self-Payment coverage and meet certain requirements for notifying the Administrative Manager. See **Section 20, COBRA Continuation of Health Coverage,** for more details.

The rates required under the Fund's reduced-rate Self-Payment Program and full-cost COBRA continuation are determined by the Board of Trustees and may be adjusted periodically. You will be advised of the applicable rates when the Administrative Manager is notified that you no longer meet the Fund's regular eligibility requirements. See Section 19, Self-Pay Rules, for the current rates and the time and place to make payments.

How do I qualify for the special lower-cost Self-Payment Program?

The special low rate is intended to help Members who are available for covered work in the Union's jurisdiction but are unable to obtain 100 or more hours of work in the trades covered by the collective bargaining agreement between the Union and contributing Employers. The special low rate is intended to reduce the hardship experienced by these unemployed and underemployed Members and their families. If you meet all of the following requirements in an eligibility month, you, as a Member or employee of the Union, qualify for the special lower rate Self-Payment Program for the related coverage month (but only for 12 months out of any 18-month period):

1. You have fewer than 100 covered hours in the eligibility month; AND

2. You are a member in good standing with the Union; AND

3. You are on the Union's "out-of-work" list; AND

4. You are not regularly working 100 or more hours in the trade for employers who do not contribute to the Plan for those hours. **Any Member who accepts regular work of 100 or more hours per month in the trade with an employer who does not contribute to the Plan for those hours will not be considered eligible for the special lower-cost Self-Payment Program.** "Work in the trade" for this purpose means work related to the underlying skills associated with a trade or craft covered by the collective bargaining agreement between the Union and contributing Employers, including any supervisory or managerial activity which is reasonably related to the underlying skills associated with such a trade or craft.

Note that the Trustees have made this lower-cost benefit available as an optional benefit, not a guaranteed right. No person acquires a vested right to such benefits. The Trustees may amend coverage, self-pay rates and otherwise exercise their discretion at any time without legal right or recourse by any person.

How long can I pay the lower-cost self payments?

The lower cost self-payment rate is available only for 12 months out of any 18-month period. The 18-month period ending before any coverage month is called the "look-back period." If you have used the lower-cost self-payment rate for 12 months out of the look-back period, you will not again be eligible for the lower-cost self-payments until the lower-cost self-payment months in the look-back period are less than 12.

Example:

Assume that you are out of work for 12 months starting with September of 2014 and you use the lower-cost self-payment program for all 12 coverage months relating to the September of 2014 through August of 2015 eligibility months. (This means that you would make self-payments for November of 2014 through October of 2015 coverage months.) You then work 100 hours in September of 2015, making you eligible for coverage for November of 2015 without a self-payment. Assume you become unemployed again and have fewer than 100 hours in October of 2015. You are NOT eligible for the lower-cost self-payment rate for the December of 2015 coverage month because you used the lower cost self-payment rate for 12 months out of the 18-month look-back period (running from June of 2014 coverage month through the November of 2015 coverage month). You remain ineligible until the first coverage month when there are less than 12 months of reduced self-payments in the preceding 18 months. In this example, that will be June of 2016, because there will only be 11 months of reduced self-payments in the period from December of 2014 through May of 2016.

When are self-payments due?

Generally, self-payments are due no later than the last day of the coverage month to which they relate. You must notify the Administrative Manager when you become unemployed by a covered Employer or subject to a reduction of hours below 100 hours per month. It is your responsibility to contact the Administrative Manager's Office to see if and when you must make self-payments to continue your eligibility.

These programs have certain election periods and requirements for timely payments. You will be advised of your rights to continue coverage under the Fund's COBRA Continuation Coverage program (under either the reduced Self- Payment rate, or the full-cost regular COBRA Continuation Coverage rate) when the Administrative Manager is notified that you no longer meet the Fund's regular eligibility requirements.

It is most important that you make a self-payment when due to continue your coverage even if you think you should be eligible by way of Employer contributions. If, after a self-payment is made, the Fund receives late contributions on your behalf that would have been sufficient to continue your eligibility, an appropriate refund of your self-payment will be made to you.

Your self-payments must be made on time. **If self-payments are not made on time your coverage will be terminated, and it will not be reinstated under the Fund's Self-Payment Program. Instead, you will be required to re-qualify under the 520-hour rule.**

Members Employed in Another Jurisdiction

See **Section 6, Special Eligibility Provisions**, subsection entitled **Reciprocity (Employment Outside the Jurisdiction of the Fund)**.

Actively at Work Participants and/or Their Spouses Who Are Age 65 or Older

What coverage is available to me while I continue to work after my Spouse or I reach age 65?

Certain federal laws regulate the coverage that must be provided to any person who is covered under the Actively at Work portion of this Plan after the person becomes eligible for Medicare benefits due to attaining the age of 65 if the Participant is Actively at Work. See **Section 17, Medicare, Supplemental Coverage, and End Stage Renal Disease**.

SECTION 3

ELIGIBILITY: RETIREES WHO RETIRE AT OR AFTER NORMAL RETIREMENT DATE

Retired Participant Benefits

Can I remain eligible for Benefits after retirement at my Normal Retirement Date?

Yes. The Trustees have established a separate program for retirees who qualify.

Note that the Trustees have made retiree benefits available as an optional benefit, not a guaranteed right. **No person acquires a vested right to such benefits, either before or after retirement**. The Trustees may amend retiree coverage, self-pay rates and otherwise exercise their discretion at any time without legal right or recourse by any person.

You, as a Member, Non-Bargaining Unit Employee or employee of the union, qualify for Plan coverage as a retiree if you

1. are entitled to a pension benefit from UA Local 190 Pension Plan; AND

2. if a Union member, you remain a member in good standing with the Union; AND you EITHER:

    a) have 35 years of vesting credit under the UA Local 190 Pension Plan; OR

    b) meet all of the following requirements:

        i) had at least three hundred seventy-five (375) hours of Employer contributions remitted to the Plan in each of the last ten (10) full Plan Years immediately before retirement (or, in Plan Years with less than 375 hours remitted, you prove to the Trustees' satisfaction that you were available for work in the jurisdiction but insufficient work was available in the jurisdiction for you to reach the 375 hours); AND
        ii) had at least ten thousand (10,000) hours of Employer contributions remitted to the Plan in the ten (10) years immediately before retirement (the "10-year look-back period"); AND
        iii) are a Participant in this Plan at the time of your retirement; AND
        iv) enroll in coverage when it first becomes available to you.

Once you decline retiree coverage, you will not be eligible again.

If you return to work following retirement and you are a Medicare-Eligible Retiree, your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan terminates and you become covered under the UA Local 190 Health and Welfare Plan immediately upon your return to work, without having to complete a new period of 520 hours of covered employment. Once you stop working, your coverage under the UA Local 190 Health and Welfare Plan terminates and your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan resumes.

What if I do not meet the retiree coverage requirements listed above?

If you do not meet the first two retiree coverage requirements listed above, you cannot obtain coverage as a retiree unless you return to work and fulfill all of the requirements listed above. If you do not meet either the requirement listed under 2.a) above, or all of the requirements listed under 2.b) i. through iv. above, you cannot obtain coverage as a retiree unless you return to work and fulfill all of the requirements listed above, or the Trustees agree to make a special exception. The circumstances that the Trustees will consider when making special exceptions will include the reasons you do not meet the requirements, and how recent and substantial was your participation in the Plan. These rules are designed to avoid adverse selection and avoid admitting retirees into Plan participation when they have not had significant contributions paid into the Plan during the years immediately preceding retirement.

Exceptions will be granted only when the Trustees determine, in the Trustees' sole discretion, that one or more of the following criteria are met:

- the retiree substantially met the requirements;
- the retiree's failure to meet all of the requirements was not material in light of the purposes of the retiree coverage requirements;
- the retiree's failure to meet all of the requirements was due to circumstances beyond the retiree's control;
- substantial and recurring contributions were made to the Plan on the retiree's behalf in most of the years leading up to the retiree's retirement.

The Trustees retain the right to deny coverage when the requirements for retiree coverage are not met.

What if I am on Disability Retirement during the ten (10) years immediately before I qualify for Normal Retirement?

If you are on Disability Retirement during any portion of the 10 years before Normal Retirement, you will be credited with hours of Employer contributions for the period of Disability Retirement as follows:

You will be credited with the greater of the following for each year (pro-rated for fractions of a year) that you draw Disability Retirement Benefits during the 10-year look-back period used for determining retiree health eligibility:

- the average hours of Employer contributions paid to the Plan by Employers for you during the years (pro-rated for fractions of a year) in the 10-year look-back period before you began to draw Disability Retirement Benefits; or
- 1,000 hours of Employer contributions for each year (pro-rated for fractions of a year) that you draw Disability Retirement Benefits during the 10-year look-back period.

Plan Programs Available to Retirees

What Plan programs are available to me and my Spouse and Children after I retire?

Upon retirement, provided the qualifications are met, you as the retired Participant and after your death, your unmarried Surviving Spouse and Children, will be eligible to continue coverage under one of the following retired Participant Self-Payment Programs:

- Retiree Self-Payment Program.
- Totally and Permanently Disabled Self-Payment Program.
- Early Retiree Self-Payment Program.
- Surviving Spouse and Children Self-Payment Program.
- Supplement to Medicare Program.
- COBRA Continuation of Health Coverage.

A brief description of the qualifications and benefits for each of the programs is set forth in appropriate sections of this Summary Plan Description. Full information is available from the Administrative Manager's Office.

Method of Payment for Coverage

How do I pay for coverage as a Retiree?

Self-payments are required to provide coverage under all of these programs. The self-payment rates are established by the Trustees, may be changed from time to time, and may be different for different self-payment Programs. The current self-payment rates can be obtained from the Administrative Manager's office. See **Section 19, Self Pay Rules** for payment time and place.

Coverage for Retired Participants' Spouse and Children

Are my Spouse and Children covered when I retire?

A Spouse or Child may also be covered through the Retiree Self-Payment Program, but the Spouse or Child must obtain coverage under the Plan at the time of the Participant's retirement. Otherwise, the Spouse or Child becomes ineligible. If the Spouse or Child is also eligible for Medicare, coverage will be provided for the Spouse or Child under the Supplement to Medicare Schedule of Benefits. A Medicare-eligible covered Spouse or Child will be treated as having obtained both Medicare Part A and Part B coverage.

Differences in Coverage for Medicare-Eligible Retirees

Are there any differences in coverage for Medicare-Eligible Retirees?

A Medicare-Eligible Retiree Member and the Member's covered Spouse and/or Child will not have prescription medicine expenses count toward the TrOOP annual out-of-pocket limit. If you are Medicare-eligible but not a retiree, your prescription medicine expenses will count toward the TrOOP annual out-of-pocket limit.

SECTION 4

ELIGIBILITY: EARLY RETIREES

Eligibility and Coverage Provisions, Payment

May I retire early and continue to be covered?

Yes, covered Participants who retire after the age of 55 and before the age of 60 are considered Early Retirees with the Fund until such time as they attain age 65 or otherwise become entitled to Medicare benefits. After that, you are entitled to purchase supplemental coverage. See **Section 17, Medicare, Supplemental Coverage, and End Stage Renal Disease**.

Your eligibility requirements for coverage and your self-payment obligation as an Early Retiree, including your Spouse and Children, are the same as eligibility requirements for coverage for normal retirement age retirees. Please see the preceding **Section 3, Eligibility: Retirees who retire at or after Normal Retirement Date**.

If, while an Early Retiree you become eligible for Medicare due to disability, your coverage will be provided under the Supplement to Medicare Schedule of Benefits. You are expected to obtain both Medicare Part A and Part B coverage.

If I am not a Participant at the time I wish to become an Early Retiree, can I still be covered?

Only if you satisfy the Trustees that you qualify for a special exception. See the preceding **Section 3, Eligibility: Retirees who Retire at or after Normal Retirement Date**.

Early Retirees' Spouse and Children

Are my Spouse and Children covered if I am an Early Retiree?

Yes, under the same conditions as coverage for Spouses and Children of normal retirement age retirees. Please see the preceding **Section 3, Eligibility: Retirees who Retire at or after Normal Retirement Date**.

Schedule of Benefits for Early Retirees

What is my schedule of Benefits as an Early Retiree?

The schedule of benefits for Early Retirees and their Spouses and Children (who are not eligible for Medicare) is the same as the schedule of benefits in effect for Actively at Work (Non-Retired) Participants, with the exception of Life Insurance Death Benefits and Accidental Death and Dismemberment Benefits (both under the basic coverage and supplemental coverage options) and Loss of Time Benefits, which are not provided.

Method of Payment for Coverage

How do I pay for coverage as an Early Retiree?

Please see **Section 19, Self Pay Rules**.

Early Retiree Reinsurance Program

Does our Plan participate in the Early Retiree Reinsurance Program?

Yes. The notice on the following page is required by law to be provided to you:

SECTION 5

ELIGIBILITY: DISABLED OR DECEASED PARTICIPANTS

Eligibility if Disabled

What if I am disabled for a period of time and can't work?

If you are injured or ill and can't work, and you were a Participant at the date of your illness or injury, your Benefits can, under most circumstances, continue under a Self-Payment Program for the same rate and eligibility period as an actively at work Member. Self-payments are made for 12 months at a reduced COBRA rate. See **Section 19, Self Pay Rules.** In addition, when you become ineligible for the Self-Payment Program, you may continue your coverage under the Fund under higher cost COBRA Continuation of Health Coverage rate.

Under unusual circumstances, you may be able to continue coverage under the reduced COBRA rate applicable to active members, but only if the Trustees agree to make a special exception. Exceptions will be granted only when the Trustees determine, in the Trustees' sole discretion that all of the following criteria are met:

- Requiring payment of the full COBRA rate would create a significant financial hardship for you;
- That substantial and recurring contributions were made to the Plan on your behalf in the most recent years leading up to your disability; and
- The circumstances under which you incurred your injury or illness were and continue to be beyond your control.

The "Self-payments" period and the "COBRA Continuation" period together cannot exceed 18 months (and comprise the total required continuation period as provided by COBRA). However, if you are determined by the Social Security Administration to be disabled within 60 days of the date you begin self-payments, this period may be extended by up to an additional 11 months (or as otherwise provided pursuant to the "COBRA" statute) if you provide timely notice to the Administrative Manager. See **Section 20, COBRA Continuation of Health Coverage.**

Eligibility if Totally and Permanently Disabled

If I am totally and permanently disabled from work, may I continue coverage for my Spouse and Children and myself?

Yes, you may continue coverage on a self-payment basis, except for Loss of Time Benefits (which are not included). When you become eligible for retirement benefits under the UA Local 190 Pension Plan (other than Disability Retirement Benefits) you lose Life Insurance Death Benefits and Accidental Death and Dismemberment Benefits, unless you convert your coverage to individual coverage at that time. When you reach age 65 or otherwise become eligible for Medicare, you may continue only Medicare supplemental coverage. Once you are a Medicare-Eligible Retiree (age 65 or older), your prescription medicine costs do not count towards TrOOP annual out-of-pocket limit. The same eligibility rules apply for your Spouse and Children as if you were retired. See **Section 17, Medicare, Supplemental Coverage and End Stage Renal Disease.**

Rules for Eligibility and Continued Coverage

What are the rules for eligibility and continued coverage as a Totally and Permanently Disabled Participant?

To obtain coverage under the Fund as a Totally and Permanently Disabled Participant, you must be receiving monthly disability pension benefits from the UA Local 190 Pension Plan.

In general, you are considered Totally and Permanently Disabled if you are no longer able to perform the duties of your job or occupation, as described and determined under the terms of the UA Local 190 Pension Plan.

If you are receiving a monthly disability pension benefit at age 60, you will convert to normal retiree status and the retiree self-payment rules will apply.

After the Social Security Administration has declared you Totally and Permanently Disabled for two years, you will be eligible to receive Medicare benefits. Once you attain the age of 65 or otherwise become eligible for Medicare, even though you will be limited to supplemental coverage, you may continue to provide coverage for your Spouse and any eligible Children under the Self-Payment Program until your Spouse attains the age of 65 or otherwise becomes eligible for Medicare and/or you no longer have any eligible Children. Note that once you become a Medicare-Eligible Retiree, your prescription medicine costs will not count towards the annual out-of-pocket limit. For this purpose, a Medicare-Eligible Retiree is defined as a retiree who is age 65 or older. If you are Medicare-eligible but are not a retiree or have not yet reached age 65, your prescription medicine costs will count towards the "TrOOP" annual out-of-pocket limit (see **"What You Must Pay"** in Section 8).

It is your responsibility as a Totally and Permanently Disabled Participant to provide the Administrative Manager's Office with a copy of your Medicare card as soon as you obtain such card. As a Totally and Permanently Disabled Participant, it is assumed you have obtained both Medicare Part A and Part B coverage when you were eligible to receive them. Your supplemental coverage applies as if you had received all Medicare Part A and Part B benefits, whether you have received them or not, so to have all available coverage you must get both Medicare Part A and Part B coverage.

Every Totally and Permanently Disabled Participant is expected to make timely application for disability benefits from Social Security and Medicare. The benefits available to you from the Fund when you are eligible for Medicare are provided under the supplement to Medicare benefits. Claims must first be submitted to Medicare and then to the Fund. If you don't sign up with Medicare, you will still only get supplemental coverage. See **Section 17, Medicare, Supplemental Coverage and End Stage Renal Disease.**

As a Totally and Permanently Disabled Participant, you must be a Participant by either Employer contributions or self-contributions on the date of disability or retirement to be eligible to be a Participant in the Totally and Permanently Disabled Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the Actively at Work Program.

Schedule of Benefits for Totally and Permanently Disabled Participants

The schedule of benefits for Totally and Permanently Disabled Participants who have not elected retirement benefits (other than Disability Retirement Benefits) is the same as the schedule of benefits in effect for Actively at Work Participants, with the exception of Loss of Time Benefits, which are not available for Totally and Permanently Disabled Participants.

Eligibility for Surviving Spouse and Children if the Participant Dies

Can my Surviving Spouse and/or eligible Children continue coverage if I die?

Yes, if you were covered as a Participant, either Actively at Work or as a retiree, at the time of your death, your Surviving Spouse and/or surviving Children may continue to obtain coverage on a self-payment basis. Your Surviving Spouse or surviving Children should contact the Administrative Manager's Office for details in this event. If your Surviving Spouse remarries, your Surviving Spouse will no longer be eligible (but your Children will). Otherwise, your Surviving Spouse may continue coverage through self-payment including supplemental coverage after becoming eligible for Medicare. No Accidental Death and Dismemberment Benefits, Life Insurance Death Benefits or Loss of Time Benefits are available, however. The same eligibility requirements for Surviving Spouses and Children must be met as if you were still a Participant.

Workers' Compensation Benefits

What if I am receiving workers' compensation benefits?

If you are receiving workers' compensation benefits, you may continue to obtain coverage on a self-payment basis, for a maximum of 36 months, which runs concurrently with the COBRA continuation coverage period. Please refer to **Section 19 - Self Pay Rules -** for the rates of coverage. Coverage is available at one rate for the first twelve months, a second rate for the second twelve months and a third rate for the third twelve months of coverage. After 36 months, you are no longer eligible for coverage.

While you are receiving workers' compensation benefits and in order to receive coverage under the Plan, you must prove you are receiving workers' compensation benefits, and must periodically provide such proof to the Fund Office in order to remain eligible to receive coverage under the Plan at the special workers' compensation rates. In addition, you must notify the Fund Office when you stop receiving workers' compensation benefits.

Once you have elected to retire (under either disability retirement or normal retirement), you must pay the retiree rates, rather than the workers' compensation rates.

SECTION 6

SPECIAL ELIGIBILITY PROVISIONS
(NOT COVERED UNDER THE ACTIVELY AT WORK AND RETIRED PARTICIPANT SECTIONS)

Military Service

What coverage is available to me if I enter military service?

Effective September 17, 2001, the Trustees resolved that, until further notice, any Member who is drafted or called into service from the reserves of the U.S. Armed Forces will have free coverage under the Plan while engaged in active duty.

If you, while a Member, are inducted into the active or reserve components of United States uniformed services **and the exception stated above does not apply to you** continuation of your health coverage under the Plan is governed by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), and the following paragraphs apply to you.

- If you are a Participant on the date of induction, your eligibility as an Actively at Work Participant will cease as of the first day of the month coincident with or next following the date you are absent due to qualifying military service for a period of over 30 days. If your absence due to military service lasts 30 days or less, you will remain eligible as an Actively at Work Participant. If you are absent due to qualifying military service for a period of over 30 days, absent an election of continuation coverage, your coverage under the Plan will terminate effective the first of the month coincident with or following 31 days of leave.

- If possible under the circumstances, you must notify the Administrative Manager of your induction in advance. Either the Member or an appropriate officer of the uniformed services may provide this notice. Advance notice is not required when military necessity prevents advance notice or other circumstances make it impossible or unreasonable to provide advance notice. In all other cases, you should provide notice to the Administrative Manager at least 30 days prior to departure for military service when it is feasible to do so. Oral or written notice is acceptable.

- A Member entering qualifying military service may elect to continue coverage, on a totally self-contributory basis, for himself/herself, Spouse and Children, assuming the Member, Spouse and Children were covered under the Plan on the day before leaving for military service, for a period of up to 24 months. The maximum period of continuation coverage due to qualifying military service is the lesser of the 24 month period beginning on the date on which the Member's absence begins, or the period beginning on the date on which the Member's absence begins and ending on the date on which the Member fails to apply for or return to a position of employment as determined under USERRA. If the Member is absent for less than 31 days as a result of military service, he or she will not be charged more than the Member's normal share of the cost of coverage.

- The COBRA provisions on electing and paying for coverage located in Section 20 of this Summary Plan Description govern in the case of electing and paying for coverage under USERRA, to the extent that such provisions do not amount to a violation of USERRA. For example, when military necessity prevents a Member from making an election of continuation coverage, or when it is impossible or unreasonable for the Member to do so, the Member will be excused from the Plan's provisions which limit the time period in which to make elections and make payments for continuation coverage, and may request reinstatement of health coverage retroactively upon the Member's election to continue coverage and payment of all unpaid amounts due. However, when a Member is not precluded by military necessity from notifying the Plan Administrator of military leave and from electing continuation coverage, and when it is not impossible or unreasonable for a Member to provide such notice and make an election, the Plan's provisions under the COBRA section govern the election of and payment for continuation coverage under USERRA.

- If the Member returns from military service and is reemployed, he or she will not be subject to any exclusion or waiting period for health insurance coverage if the exclusion or waiting period would not have been imposed had the coverage not been terminated because of military service, whether or not the Member elects or rejects continuation coverage. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

- Upon your reemployment under USERRA, your health plan coverage will be reinstated.

Self-Employed Plumbers, Pipefitters, Service Technicians, and Gas Distribution Workers (Sole Proprietorships and Partners)

What coverage is available to me if I am self-employed or a partner?

None. An individual who is self-employed as a sole proprietorship or as a partner is not considered an employee, and thus is prohibited from participating in the Plan. A business owner whose business is incorporated and who is an employee of the business is eligible.

Reciprocity (Employment Outside the Jurisdiction of the Fund)

What if I work as a Plumber, Pipe Fitter, Service Technician, or Gas Distribution Worker under another union's jurisdiction?

It is not unusual for a Plumber, Pipefitter, Service Technician, or Gas Distribution Worker to accept employment outside the jurisdiction of Local 190 when there is no work available locally.

The Plan has entered into reciprocity agreements with many other Funds covering Plumbers, Pipefitters, Service Technicians, or Gas Distribution Workers. The purpose of reciprocity agreements is to:

- Forward contributions paid into the trust fund of the other jurisdiction to the Local 190 Fund where the Plumber, Pipefitter, Service Technician, or Gas Distribution Worker is normally employed so that the Plumber, Pipefitter, Service Technician, or Gas Distribution Worker can remain eligible.

- Accept contributions transferred from other trust funds so the traveling Plumber, Pipe Fitter, Service Technician, or Gas Distribution Worker's eligibility for benefits under the Local 190 Fund will continue.

If you work in the jurisdiction of another Local, it will be necessary for you to sign an authorization and request form to transfer your hours back to the Local 190 Fund. Such a form can be obtained only from the office of the Local where you are starting work, and should be executed at the time you sign in and begin work in the other Local's jurisdiction.

This Plan, different from your pension plan, is based on hours worked, not money paid in. Therefore, your coverage as a traveler under the Local 190 Plan will depend on your qualifying for the required number of work hours. If you so qualify, you may retain eligibility whether more or less money is sent by the other trust fund than is required under the Local 190 collective bargaining agreement.

When you work outside of the UA Local 190 jurisdiction, normally we will credit you with one hour for each hour worked for which the other local reciprocates the contribution to the Fund. However, when you are working in another jurisdiction and the other local reciprocates contributions at a rate higher than that of the UA Local 190, we will credit you with the number of hours equal to the amount reciprocated divided by the rate that would apply if you had performed the work in the same classification under UA Local 190's jurisdiction.

Both Spouses Eligible as Employees

If both a husband and wife are employed as a Plumber, Pipefitter, Service Technician, or Gas Distribution Worker and are both eligible as employees to be Participants in the Plan, Coordination of Benefits (COB) will be in effect for any claims incurred by either Spouse and/or any eligible Children. In effect, the Plan will coordinate benefits with itself, so that claims are not paid more than once. However, two Miscellaneous Benefits and Prescription Benefit funds will be available, one for each Participant. Refer to Section 22, Coordination of Benefits and Subrogation.

SECTION 7

BLUE CROSS BENEFIT SUMMARY

The chart below provides a very brief summary of the benefits administered for the Fund by Blue Cross Blue Shield. The coverage percentages are the percentages that Blue Cross Blue Shield will pay of its participating provider approved amount.

Until January 1, 2014, all Members and Children receive the benefits described in the "Enhanced Coverage" column, with no deductible.

Please note that effective January 1, 2014, there are two levels of Blue Cross Blue Shield coverage: "Enhanced Coverage" and "Standard Coverage." Effective January 1, 2017, in order to qualify for Enhanced Coverage for any calendar year, you must complete an annual physical or health maintenance exam during the previous calendar year. In order for the Fund Office to set eligibility for the new year properly, your annual physical or health maintenance exam must be completed by October 31 of the previous year (by October 31, 2017 for the 2018 calendar year). See Section 8, "**Requirements for Obtaining Enhanced Benefit Coverage**" for more details.

A member must complete an annual physical or health maintenance exam during the calendar year in order for the Member and the Member's family to become or remain eligible for Enhanced Coverage. In order for the Fund Office to set eligibility for the new year properly, the annual physical or health maintenance exam must be completed by October 31 of the previous year (by October 31, 2017 for the 2018 calendar year). If you first become eligible during the last six months of the calendar year, you will automatically be placed in Enhanced Coverage for the calendar year following initial eligibility, regardless of whether you have completed the annual physical exam. However, you will be required to meet the annual physical requirement to continue to be eligible for Enhanced coverage in subsequent years.

The annual physical or health maintenance exam referenced in the Plan includes an annual gynecological exam, blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination, health counseling regarding potential risk factors and for Members and Spouses covered under Medicare, the Medicare annual wellness visit.

These benefits are described more fully in Sections 8 and 9 of this Summary Plan Description, and full details are available in the separate Benefit Schedule, which will be provided by the Administrative Manager without cost to any Participant upon request.

For Preventive Care Services, levels of coverage apply where services are provided by in- network service providers (deductibles do not apply).	**Enhanced Coverage***	**Standard Coverage*,****
Routine health maintenance examination in your physician's office-select screening lab procedures including chemical profile, complete blood count or any of its components, urinalysis, chest x-ray, EKG and cholesterol testing – once per calendar year	Covered – 100%	Covered-100%
Gynecological Examination-once per calendar year, no age restrictions	Covered-100%	Covered-100%
Routine Pap smear screening – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Well-baby and child care: • 6 visits, up through 12 months old • 6 visits, 13 months through 23 months old • 6visits, 24 months through 35 months old • 2 visits, 36 months through 47 months old • Visits beyond 47 months are limited to one per member, per calendar year under the health maintenance examination benefit	Covered – 100%	Covered-100%
Immunizations – once per calendar year, no age restrictions	Covered – 100%	Covered-100%

Prostate specific antigen (PSA) screening – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Routine mammography screening – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Flexible sigmoidoscopy exam – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Fecal occult blood screening-once per calendar year	Covered-100%	Covered-100%
Routine/screening colonoscopy – once per calendar year, no age restrictions; medically necessary colonoscopies are not limited to once per member per calendar year	Covered – 100%	Covered-100%

Physician Office Services

Office, outpatient and home medical visits (non-routine)	Covered – 80% (20% co-pay)	Covered – 100% after $30.00 co-pay
Office consultations	Covered – 80% (20% co-pay)	Covered – 100% after $30.00 co-pay
Urgent care	Covered – 80% (20% co-pay)	Covered – 100% after $30.00 co-pay

Emergency Medical Care

Hospital emergency room (subject to a flat $50.00 co-payment for Enhanced Coverage and a flat $100.00 co-payment for Standard Coverage; co-payment is waived when treatment is received for an accidental injury or when the patient is admitted).	Covered – 100% after $50.00 co-pay	Covered-100% after $100.00 co-pay
Emergency medical care in a physician's office	Covered – 80% (20% co-pay)	Covered -100% after $30.00 co-pay
Ambulance services – medically necessary	Covered – 100%	Covered-80%

Diagnostic Services

Laboratory and pathology services	Covered – 100%	Covered-80%
Diagnostic tests and X-rays	Covered – 100%	Covered-80%
Therapeutic radiology	Covered – 100%	Covered-80%

Maternity Services Provided by a Physician or Certified Nurse Mid-wife

Pre-natal and post-natal care	Covered – 100%	Covered-80%
Delivery and nursery care	Covered – 100%	Covered-80%

Hospital Care

Semi-private room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Non-emergency services must be rendered in a **participating** hospital.	Covered – 100%	Covered-80%
Inpatient consultations	Covered – 100%	Covered-80%
Chemotherapy	Covered – 100%	Covered-80%

Alternatives to Hospital Care

Skilled nursing care and related physician services in a skilled nursing facility, when ordered by the attending physician – limited to 100 days per calendar year	Covered – 80% (20% co-pay) Amounts paid over the covered amount do not count toward the annual out of pocket limit	Covered-80% Amounts paid over the covered amount do not count toward the annual out of pocket limit
Hospice care	Covered – 100%	Covered-80%
Home health care – medically necessary	Covered – 100%	Covered-80%
Home infusion therapy – medically necessary	Covered – 100%	Covered-80%

Surgical Services

Surgery – includes related surgical services	Covered – 100%	Covered-80%
Presurgical consultations (second and third opinions; deductibles do not apply)	Covered – 100%	Covered-80%
Voluntary sterilization (subject to a 90 day waiting period; this waiting period shall not apply to patients who are under age 19)	Covered – 100%	Covered-80%

Human Organ Transplants

Specified human organ transplants – **in designated facilities only**, when coordinated through Blue Cross Blue Shield Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered-80%
Bone marrow transplants – when coordinated through Blue Cross Blue Shield Human Organ Transplant Program (800-242-3504); specific criteria applies	Covered – 100%	Covered-80%
Kidney, cornea and skin transplants	Covered – 100%	Covered-80%

Mental Health Care and Substance Use Disorder Treatment

Inpatient care	Inpatient mental health care	Covered – 100%	Covered-80%
	Inpatient substance use disorder treatment	Covered – 100%	Covered-80%
	Residential substance use disorder treatment	Covered – 100%	Covered-80%
Outpatient mental health care		Covered – 100%	Covered-80%
Outpatient substance use disorder treatment – in approved facilities		Covered – 100%	Covered-80%

Other Covered Services

Outpatient diabetes management program	Covered – 100%	Covered-100%
Allergy testing and therapy	Covered – 80% (20% copay)	Covered-100% after $30.00 co-pay
Chiropractic spinal manipulation – limited to 38 medically necessary visits per calendar year	Covered – 100%	Covered-100% after $30.00 co-pay
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered-80%
Durable medical equipment	Covered – 90% (10% co-pay)	Covered-80%
Non-surgical prosthetic and orthotic devices other than breast prostheses prescribed after cancer surgery, includes orthopedic shoes and non-rigid devices and supplies such as shoe inserts not attached to a medically necessary brace	Covered – 90% (10% co-pay)	Covered-80%

Private duty nursing services	Covered – 90% (10% co-pay) Amounts paid over the covered amount do not count toward the annual out of pocket limit	Covered-80% Amounts paid over the covered amount do not count toward the annual out of pocket limit
Audiometric exam once every 36 months	Covered – 100%	Covered-80%
Hearing aid evaluation test once every 36 months	Covered – 100%	Covered-80%
Ordering and fitting a monaural or binaural hearing aid up to a maximum of $5,000 once every 36 months	Covered – 100%	Covered-80%
Conformity test once every 36 months	Covered – 100%	Covered-80%
Prescription drugs	Not covered	Not covered
Deductible	$100.00 per contract	$250.00 single/$500.00 family
Co-pays	$50 (emergency room visits); 0%, 10% or 20% as noted above	$30.00 or $100.00 as noted above
Co-insurance	None	20%
Lifetime Maximum	None	None

*Enhanced Coverage and Standard Coverage levels apply effective January 1, 2014
**For Standard Coverage, Co-insurance and Deductible are subject to a maximum of $1,250.00 for single coverage and $2,500.00 for family coverage.
NOTE: You must meet your Deductible before we will provide coverage for all services other than preventive care services and presurgical consultations. Deductibles do not apply to preventive care services or presurgical consultations.
***Effective June 1, 2017, the "TrOOP" annual out-of-pocket limit for both Enhanced Coverage and Standard Coverage is $7,150 for single coverage and $14,300 for two person or family coverage. All Deductibles, Co-payment, Co-insurance and other charges for covered services are counted toward the TrOOP out-of-pocket limit, subject to the following exceptions: Amounts paid for premiums, non-covered services, out-of-network balance-billed amounts do not count toward the TrOOP out-of-pocket limit. In addition, for Medicare-Eligible Retirees, prescription medicine expenses do not count toward the TrOOP out-of-pocket limit.
****Coverage for Preventive Care Services are updated automatically at the beginning of each Plan Year for additional benefits as mandated under PPACA. A complete list of these services is located at http://www.uspreventiveservicestaskforce.org.

SECTION 8

HEALTH CARE COVERAGE – BASIC BENEFITS ADMINISTERED BY BLUE CROSS BLUE SHIELD

This portion of the Summary Plan Description provides a brief summary of the coverage provided under the Plan's contract with Blue Cross Blue Shield for health care coverage. It is arranged in the following sub-sections:

- **Requirements for Obtaining Enhanced Coverage**
- **What You Must Pay**
- **Coverage for Hospital, Facility and Alternatives to Hospital Care**
- **Coverage for Physician and Other Professional Provider Services**
- **Coverage for Other Health Care Services**

Requirements for Obtaining Enhanced Coverage

Please note that effective January 1, 2014, there are two levels of Blue Cross Blue Shield coverage: "Enhanced Coverage" and "Standard Coverage." Effective January 1, 2017, in order to obtain Enhanced Coverage for any calendar year, you must complete an annual physical exam or health maintenance exam during the previous calendar year. In order for the Fund Office to set eligibility for the new year properly, the annual physical or health maintenance exam must be completed by October 31 of the previous year (by October 31, 2017 for the 2018 calendar year and so on for each calendar year). You must also provide proof of having done so to the Fund Office by October 31 of the previous calendar year. If you first become eligible during the last six months of the calendar year, you will automatically be placed in Enhanced Coverage and will remain in Enhanced Coverage during the following calendar year regardless of the annual physical requirement. However, you must meet the annual physical requirement in order to remain in Enhanced Coverage in subsequent years.

The annual physical or health maintenance exam referenced in the Plan includes an annual gynecological exam and for Members and Spouses covered under Medicare, the Medicare annual wellness visit.

What You Must Pay

This section explains the Deductible, Co-payments and Co-insurance you must pay each calendar year for health care coverage.

Deductibles, Co-pays and Co-insurance

Your Plan requires you to pay Deductibles and Co-pays. In addition, Standard Coverage requires you to pay "Co-insurance."

Deductible Requirements

A Deductible is an annual amount that you must pay prior to the Plan paying any amount.

If you have Enhanced Coverage, your Deductible is $100.00 per "contract." This means that no matter how many family members are covered through a Member, only one $100 Deductible must be met.

If you have Standard Coverage, your Deductible is $250.00 per individual, maximum $500.00 per family. Deductibles count for determining whether you have met the Standard Coverage out-of-pocket maximum.

Deductibles do not apply to Preventive Care Services (page 71) and do not apply to Pre-surgical Consultations (page 61).

Additional Cost-Sharing For Enhanced Coverage

Under Enhanced Coverage, all additional cost-sharing requirements are called "co-payments" or "co-pays." You must pay a co-pay for the following services:

- $50.00 co-payment for each facility/hospital emergency room visit; the co-payment is waived when treatment is received for an accidental injury or when the patient is admitted.

- All physician visits outside of a hospital have a 20% co- payment, including:
  - Allergy Testing & Therapy Office Outpatient and Home Visits and Office Consultations;
  - Medical Eye Exams (exams due to injury or related to covered medical condition);
  - Emergency Medical Care in a physician's office; and
  - Urgent Care.

- Skilled Nursing Care: 20%

- Private Duty Nursing: 10%

- Prescribed Prosthetic and Orthotic Devices (other than Breast Prostheses following cancer surgery): 10%.

- Durable Medical Equipment (other than diabetes treatment equipment): 10%

There are no Co-payments for covered medical services other than those specified above.

Additional Cost-Sharing For Standard Coverage :

Under Standard Coverage, the flat dollar amounts that you must pay are called "Co-payments" or "Co-pays." **Co-pays do not count towards the Standard Coverage out of pocket/Co-insurance maximum.**

Standard Coverage Co-Payments

You must pay a Co-pay for the following services:

- All physician visits outside of a hospital have a $30.00 Co-payment, including:
  - Allergy Testing & Therapy;
  - Office Outpatient and Home Visits and Office Consultations;
  - Medical Eye Exams (exams due to injury or related to covered medical condition);
  - Emergency Medical Care in a physician's Office;
  - Urgent Care; and
  - Chiropractic Services

Standard Coverage Co-Insurance

The percentage amounts that you must pay are called "Co-insurance." Under Standard Coverage, all services other than covered Preventive Care services, **Specified Human Organ Transplants (page 46), Hospice Care and** Presurgical Consultations and services subject to Co-payments have a 20% Co-insurance requirement.

Standard Coverage Out-of-Pocket Maximum

The Standard Coverage out-of-pocket maximum is the maximum amount of Standard Coverage Deductible and Standard Coverage Co-insurance you can be required to pay per calendar year. Once the Standard Coverage out-of-pocket maximum is met, the services that are otherwise subject to the 20% Co-insurance requirement are paid 100% by the Plan. The maximum amount of out-of-pocket expenses is $1,250 for single coverage and $2,500 for two person or family coverage.

The following out-of-pocket expenses count toward the Standard Coverage out-of-pocket maximum:

- Standard Coverage Deductible (first $250 per individual, $500 per family)
- Standard Coverage Co-insurance (20% of all services other than covered Preventive Care services, Specified Human Organ Transplants, Hospice Care, Presurgical Consultations and services subject to Co-payments)

None of these cost-sharing amounts are eligible for reimbursement under your Miscellaneous Benefit but they may be reimbursed under your Individual HRA.

The following out-of-pocket expenses do not count toward the Standard Coverage out-of-pocket maximum:

- Standard Coverage Co-payments (for example, the $30 Co-payments for physician office visits)
- Prescription Medicine expenses after your $1,440 allowance is used up

True Out-of-Pocket ("TrOOP") Annual Limit

The Affordable Care Act (ACA) requires that all health insurance issuers and group health plans that cover more than one active employee use a uniform maximum for out-of-pocket expenses. The new definition of "out-of-pocket" expenses includes deductibles, coinsurance, and copayments including drugs, office visits, and all other expenses covered but not paid primarily by the plan. Because of this more comprehensive definition, sometimes the ACA out-of-pocket maximum is called a "true" out-of-pocket maximum. To distinguish this from the Standard Coverage out-of-pocket maximum, we will refer to this as the "TrOOP" maximum.

There are a few things that are not included in the out-of-pocket maximum. For example, balance billing amounts for out-of-network providers and expenses for non-covered services are still excluded.

The TrOOP maximum is applied based on the calendar year. It increases at the start of each Plan Year. As of June 1, 2017, the TrOOP for 2017 for the Plan became $7,150 per person, not to exceed $14,300 per family. Once your total out-of-pocket expenses reach this amount, all expenses are paid 100% by the Plan. The TrOOP maximum applies whether you are in the Enhanced Plan or the Standard Plan.

Starting June 1, 2015, if you are not a Medicare-Eligible Retiree (a retiree aged 65 or older), your out-of-pocket expenses for prescription medicines obtained when using your Blue Cross Blue Shield card are counted when determining if you have reached the TrOOP maximum, and if you are not a Medicare-Eligible Retiree, covered prescription medicines obtained when using your Blue Cross Blue Shield card are paid at 100% of the approved amount once you have reached the TrOOP maximum.

If you are a Medicare-Eligible Retiree (a retiree aged 65 or older), your out-of-pocket expenses for prescription medicines are not counted when determining if you have reached the TrOOP maximum, and you will not become eligible for 100% prescription coverage once your Plan TrOOP maximum is reached. The Medicare Retiree Health and Welfare Plan does not include this feature (although cost-sharing for services and covered items other than prescription drugs count toward TrOOP for Medicare-Eligible Retirees). Medicare-Eligible Retirees are encouraged to get Medicare Part D coverage, which has an ever lower Part D TrOOP maximum, after which Medicare pays 100% of prescription drug costs.

Other Limitations On Certain Benefits

Skilled Nursing Maximum Days Per Year

Covered stays in a Skilled Nursing Facility are limited to 100 days per calendar year.

Chiropractic Services

The Plan pays for spinal manipulation to treat misaligned or displaced vertebrae of the spine, with a maximum of 38 visits per Member per year (with a $30.00 per visit co-pay with Standard Benefit Coverage), and one office visit per 12-36 months, depending on the circumstances. See **Chiropractic Services** under **Coverage for Physician and Other Professional Provider Services.**

Hearing Care

We will pay for the audiometric examination, hearing aid evaluation and conformity tests once every 36 months. We will pay for a hearing aid up to a maximum of $5,000 once every 36 months. We will not pay for hearing care services you receive from a Nonparticipating Provider. See **Hearing Care** under **Coverage for Other Health Care Services.**

Waiting Periods

Effective January 1, 2014, there is no waiting period for the treatment of pre-existing conditions.

Coverage For Hospital, Facility And Alternatives To Hospital Care

This section describes the hospital, facility and alternatives to hospital care covered under the Health Care Plan. It includes:

- **Hospital And Facility Care**
  - Inpatient Hospital Services That Are Payable
  - Inpatient Hospital Services That Are Not Payable
  - Hospital Admissions That Are Not Payable
  - Outpatient Hospital Services That Are Payable
  - Outpatient Hospital Services That Are Not Payable
  - Outpatient Mental Health Facility Services
  - Residential and Outpatient Substance Abuse Treatment
  - Freestanding Ambulatory Surgery Facility Services
  - Freestanding Outpatient Physical Therapy Facility Services
  - Freestanding ESRD Facility Services
  - Long-Term Acute Care Hospital Services
- **Alternatives To Hospital Care**
  - Home Health Care Services
  - Home Infusion Therapy
  - Hospice Care Services
  - BlueHealthConnection Program
  - Integrated Case and Disease Management
  - Alternative Facility Services That Are Not Payable
- **How Hospitals, Facilities And Alternative To Hospital Care Providers Are Paid**
  - Participating Providers
  - Nonparticipating Providers

- Emergency Services at a Nonparticipating Hospital
- Emergency Services at a Michigan Nonparticipating Hospital
- Services That You Must Pay
- Out-of-State Providers
- BlueCard Program

Hospital And Facility Care

The services described in this section must be:

- Prescribed by the attending physician, and
- Provided during an inpatient hospital stay or
- Provided in the outpatient department of a hospital or facility
- Hospice Care Services
- For covered services to be payable, they must be medically necessary as defined in Section 25, except as provided in **Coverage for Other Health Care Services** under **"Preventive Care."**

  NOTE: Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting.

Inpatient Hospital Services That Are Payable

- Semiprivate room
- Nursing services
- Meals, including special diets
- Operating room services, including delivery and surgical treatment rooms
- Services provided in a special care unit, such as intensive care
- Anesthetics given by a qualified employee of the hospital
- Diagnostic laboratory and pathology tests/services that are provided under the direction of a pathologist employed by the hospital
- Oxygen and other therapeutic gases and their administration
- Psychological tests directly related to the condition for which the patient is admitted or when such tests have a full role in rehabilitative or psychiatric treatment programs
- Medical supplies such as gauze, cotton, fabrics, plaster and other materials used in dressings and casts
- Cardiac rehabilitation services begun during an admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
- Physical therapy treatment, speech and language pathology services, and occupational therapy used to treat the condition for which the Member is hospitalized, provided the therapy and services meet the requirements described in the Summary Plan Description to be covered.

- Sterilization, whether medically necessary or not. If not medically necessary, a 90-day waiting period applies.

- Prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) that are:

    - Labeled "Rx Only" as defined under the amended Federal Food, Drug and Cosmetic Act and
    - Used during your stay in the hospital
    - Maternity care and routine newborn nursery care during a mother's eligible hospital stay

Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section

However, we may pay for a shorter stay if the attending provider (e.g., your physician or certified nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Also, we may not set the level of benefits or out-of-pocket costs so that any portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain preapproval. Under this Plan, preapproval is generally required only if you enter an inpatient long-term acute care hospital or use a noncontracted hospital under certain circumstances. For information on preapproval, contact your Blue Cross Blue Shield customer service representative.

- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration

- Drugs that are FDA-approved for use in chemotherapy treatment

    NOTE: If the FDA has not approved the drug for the specific disease being treated, Blue Cross Blue Shield's Medical Policy staff determines the appropriateness of the drug for that disease by using the following criteria:

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

- Inhalation therapy

- Electroshock therapy

- Pulmonary function evaluation

- Radioactive isotope studies and use of radium owned or rented by the hospital

- Prosthetic devices permanently implanted in the body or those used externally as part of regular hospital equipment while you are in the hospital (for additional prosthetic and other orthotic benefits)

- External prosthetic and orthotic devices prescribed by a physician for use outside of the hospital

- Cost of obtaining, preserving and storing human skin, bone, blood, and bone marrow to be used for medically necessary covered services

- Hyperbaric oxygenation (therapy given in a pressure chamber)

- Computerized axial tomography, magnetic resonance imaging and positron emission tomography scans provided in participating facilities

- Durable medical equipment:

  - Used in the hospital
  - Rented or purchased from the hospital at the time of discharge

- Cosmetic surgery for:

  - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
  - Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
  - Conditions caused by accidental injuries, and
  - Traumatic scars

  NOTE: Cosmetic surgery and related services are not payable when the services are primarily performed to improve appearance.

- Dialysis services, supplies and equipment to treat:

  - Acute renal (kidney) failure
  - End stage renal disease (ESRD)

    ESRD treatment may also be provided in a participating freestanding facility or in the home (when provided through a program participating with Blue Cross Blue Shield to provide such services).

  NOTE: Dialysis services used primarily to treat ESRD are also covered by Medicare (individuals with ESRD should apply to Medicare).

- Psychiatric day treatment or psychiatric night treatment. We pay for:

  - Services provided by facility staff
  - Ancillary services to patients who are admitted and discharged on the same day of treatment
  - Prescribed drugs given by the hospital in connection with the treatment plan
  - Electroshock therapy when administered by, or under the supervision of, a physician
  - Anesthetics for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy
  - Psychological testing
  - Family counseling

- For patients admitted to a **psychiatric night treatment** facility, we also pay for:

  - A semiprivate room
  - Nursing services
  - Meals, including special diets

- Services performed to obtain, test, store and transplant only the following human tissues and organs:

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

NOTE: We will pay covered services for a donor if the donor does not have transplant benefits under any health care plan.

- Bone Marrow Transplants

  When directly related to up to two single transplants per Member, per condition, we pay for certain services for both allogeneic transplants and autologous transplants for many specific conditions under circumstances specified in detail in the Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

  We do not pay the following for bone marrow transplants:

  - Services that are not medically necessary (see Section 25 for the definition of medical necessity)
  - Services provided by persons or entities that are not legally qualified or licensed to provide such services
  - Services rendered to a donor when the donor's health care coverage will pay for such services
  - Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
  - An autologous tandem transplant for any condition other than germ cell tumors of the testes
  - An allogeneic tandem transplant
  - The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
  - Experimental treatment
  - Any other services or admissions related to any of the above named exclusions

Note that bone marrow transplants are <u>not</u> considered "Specified Human Organ Transplants" as that term is used in this Summary and Plan.

- Specified Human Organ Transplants

  When performed in a designated facility, we pay for transplantation of the following organs, **which are referred to as "Specified Human Organ Transplants:"**

  - Combined small intestine-liver
  - Heart
  - Heart-lung(s)
  - Liver
  - Lobar lung
  - Lung(s)
  - Pancreas
  - Partial liver
  - Simultaneous pancreas-kidney
  - Small intestine (small bowel)

  All payable **Specified Human Organ Transplant** services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the benefit period that begins five days before, and ends one year after, the organ transplant.

  When directly related to the transplant, we pay for specific services and supplies under circumstances specified in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

  <u>Limitations and Exclusions</u>

  During the benefit period, deductibles, co-insurance and co-payments do not apply to the Specified Human Organ Transplants and related procedures.

We do not pay the following for specified human organ transplants:

- Services that are not Blue Cross Blue Shield benefits
- Living donor transplants other than partial liver, lobar lung, and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- 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 surgery and related services performed in a nondesignated facility. You must pay for the transplant surgery and related services you receive in a nondesignated facility.
- Transportation, meals and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered directly related to travel, meals and lodging (examples include, but are not limited to the following: dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, household utilities (including cellular telephones), maids, babysitters or daycare services and entertainment (such as cable television, books, magazines and movie rentals))
- Services prior to your **Specified Human Organ Transplant** surgery, such as expenses for evaluation and testing, unless covered elsewhere under this Summary Plan Description

Experimental transplant procedures. See **Section 9 for guidelines related to experimental treatment**.

Inpatient Hospital Services That Are Not Payable

In addition to the services described as nonpayable throughout the previous subsection, we also do not pay for the following:

- Services that may be medically necessary but can be provided safely in an outpatient or office location
- Services of physicians and surgeons not employed by the hospital (see **Coverage for Physician and Other Professional Provider Services**)
- Custodial care or rest therapy
- Psychological tests if used as part of, or in connection with, vocational guidance training or vocational counseling
- Human organ transplants, except those specifically listed in this Summary Plan Description
- Dental services. However, certain procedures may be payable as medical services if performed in a hospital because the patient has a dental condition that is adversely affecting medical condition under circumstances specified in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request
- Services covered under any other health care benefits plan
- Artificial and endodontic implants and related services, including repair and maintenance of implants and surrounding tissue

Hospital Admissions That Are Not Payable

Hospital admissions that are not covered by your Plan include:

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

- Observation
- Dental treatment, including extraction of teeth, except as otherwise noted in this Summary Plan Description
- Diagnostic evaluations
- Lab exams
- Electrocardiography
- Weight reduction (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
- X-rays, exams or therapy
- Cobalt or ultrasound studies
- Basal metabolism tests
- Convalescence or rest care
- Convenience

- Those mainly for physical therapy, speech and language pathology services or occupational therapy

Outpatient Hospital Services That Are Payable

The services listed under "Inpatient Hospital Services That Are Payable" are also payable when provided as outpatient care (except for those related to inpatient room, board and inhalation therapy). However, the following requirements must also be met when services are provided on an outpatient basis:

- Emergency room services are payable when provided for the initial examination and treatment of medical emergencies or accidental injuries, subject to a $50.00 Co-payment for Enhanced Coverage and a $100.00 Co-payment for Standard Coverage for each facility/hospital emergency room visit. This Co-payment requirement is waived when treatment is received for an accidental injury or when the patient is admitted. However, we do not pay for follow-up care unless covered separately under another provision. In addition, for services received on or before December 31, 2013, benefits obtained from a nonparticipating/nonpanel hospital are limited to $25 per condition.

- Services to treat chronic conditions are payable when they require repeated visits to the hospital.

- Drugs, biologicals and solutions administered in a hospital are payable when they are part of the treatment of the disease, condition or injury.

- Dialysis services (hemodialysis and peritoneal dialysis), supplies and equipment are payable when provided in the home to treat chronic, irreversible kidney failure. Services must be billed by a hospital participating with Blue Cross Blue Shield and must meet the following conditions:

    - The patient’s attending physician and the physician director or a committee of staff physicians of a self-dialysis training program must arrange the treatment.
    - The owner of the patient's home must give the hospital prior written permission to install the equipment.

- We pay for the following dialysis services:

    - Placement and maintenance of a dialysis machine in the patient's home
    - Expenses to train the patient and one other person who will assist the patient in the home in operating the equipment
    - Laboratory tests related to the dialysis
    - Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs
    - Removal of the equipment after it is no longer needed

- The following dialysis services are not payable:

    - Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as "back ups," including hospital personnel sent to the patient's home

- Electricity or water used to operate the dialyzer
- Installation of electric power, a water supply or a sanitary waste disposal system
- Transfer of the dialyzer to another location in the patient's home
- Physician services not paid by the hospital

- Physical therapy, speech and language pathology services and occupational therapy are payable, as described in this Summary Plan Description, when provided for rehabilitation.

- Cardiac rehabilitation services are payable when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required.

Outpatient Hospital Services That Are Not Payable

The services listed under "Inpatient Hospital Services That Are Not Payable" are also not payable when provided as outpatient care. In addition, we do not pay for:

- Outpatient inhalation therapy

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

Outpatient Mental Health Facility Services

Non-participating facility charges are only covered under very limited circumstances. See the Benefit Summary available from the Administrative manager for details.

Outpatient Mental Health Services That Are Payable

- Mental health services provided by a physician or a fully- licensed psychologist (see **Coverage for Physician and Other Professional Provider Services**)

- Services provided 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, a fully-licensed psychologist, or a limited-licensed psychologist when prescribed and billed by a physician or fully-licensed psychologist

Outpatient Mental Health Services That Are Not Payable

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

- Marital counseling

Residential and Outpatient Substance Use Disorder Treatment

Services in residential and outpatient substance use disorder treatment program facilities are payable if the following criteria for the program are met:

- Your physician must:

- Assign a diagnosis of substance use disorder
- Certify whether the treatment required is residential or outpatient
- Provide an initial exam
- Provide and supervise your care during detoxification
- Provide follow-up care during rehabilitation

- The services must be medically necessary for the treatment of your condition

- The services must be approved by Blue Cross Blue Shield and provided by an approved substance use disorder program

Substance Use Disorder Treatment Services That Are Payable

- We pay for the following services provided and billed by an approved substance use disorder treatment program:

  - Lab exams
  - Diagnostic exams
  - Supplies and use of equipment for detoxification or rehabilitation
  - Professional and other trained staff services and program services necessary for care and treatment
  - Individual and group therapy or counseling
  - Counseling for family members
  - Psychological testing
  - Treatment of tobacco dependence

- We also pay for the following in a residential substance use disorder treatment program:

  - Bed and board, including general nursing services
  - Drugs, biologicals and solutions used in the facility

- We also pay for the following in an outpatient substance use disorder treatment program:

  - Drugs, biologicals and solutions used in the program, including drugs taken home

Substance Use Disorder Treatment Services Not Payable

- Services provided primarily for a diagnosis other than substance use disorder

- Dispensing methadone or testing urine specimens, unless you are receiving therapy, counseling or psychological testing

- Diversional therapy

- Services provided beyond the period necessary for care and treatment

- Services provided during the portion of any residential admission that occurs before the effective date of this Plan

- Benefits are payable, up to the limits provided in this Summary Plan Description, for the balance of an admission when coverage under the Plan terminates during the admission

Freestanding Ambulatory Surgery Facility Services

We pay for medically necessary facility services provided by a Blue Cross Blue Shield **participating** ambulatory surgery facility. A patient must be under the care of a licensed doctor of medicine, osteopathy, podiatry or oral

surgery to be admitted to an ambulatory surgery facility. The services must be directly related to performing surgical procedures identified by Blue Cross Blue Shield as covered ambulatory surgery. **A detailed description of the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Freestanding Ambulatory Surgery Facility Services That Are Not Payable

We do not pay for:

- Services by a **nonparticipating** ambulatory surgery facility
- Professional services by a physician. These services, such as surgery, may be covered under **Coverage for Physician and Other Professional Provider Services**

Freestanding Outpatient Physical Therapy Facility Services

We pay our approved amount for services in a freestanding outpatient physical therapy facility only when the facility that provides and bills for them is a **participating** facility.

Freestanding Outpatient Physical Therapy Services That Are Payable

Physical therapy, speech and language pathology services, and occupational therapy, as described in **Coverage for Hospital, Facility and Alternatives to Hospital Care,** are payable when provided for rehabilitation.

Freestanding Outpatient Physical Therapy Services That Are Not Payable

- Services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance use disorder treatment program
- Services provided to you in the home

Freestanding ESRD Facility Services

We pay for medically necessary facility services provided by a Blue Cross Blue Shield **participating** end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney failure. **A detailed description of the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Freestanding ESRD Facility Services That Are Not Payable

- Services provided by a **nonparticipating** end stage renal disease facility
- Services not provided by the employees of the ESRD facility
- Services not related to the dialysis process

Long-Term Acute Care Hospital Services

The services listed under "Inpatient Hospital Services That Are Payable" and "Outpatient Hospital Services That Are Payable" may also be payable when provided in a long-term acute care hospital.

The services are payable only if the following conditions are met:

- The long-term acute care hospital must be located in Michigan and participate with Blue Cross Blue Shield.

- The provider must request and receive preapproval for inpatient services; outpatient services do not require preapproval.

- Long-term acute care hospital services count toward any benefit maximums that apply to inpatient and outpatient hospital services.

We do not pay for:

- Services in a nonparticipating long-term acute care hospital including emergency services

- Inpatient admissions that Blue Cross Blue Shield has not preapproved

- Out-of-state admissions, except with special approval from the Administrative Manager

Alternatives To Hospital Care

Home Health Care Services

This program provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home.

The services described below must be:

- Prescribed by the attending physician

- Provided and billed by a participating home health care agency

- Medically necessary

The following criteria must be met:

- The attending physician certifies that the patient is confined to the home because of illness.

- This means that transporting the patient to a health care facility, physician's office or hospital for care and services would be very difficult due to the nature or degree of the illness.

- The attending physician prescribes home health care services and submits a detailed treatment plan to the home health care agency.

The agency accepts the patient into its program.

A detailed description of the services and supplies that are payable is contained in the detailed benefit schedule. A free copy of the detailed benefit schedule is available from the Administrative Manager on request.

Services That Are Not Payable

- General housekeeping services

- Transportation to and from a hospital or other facility

- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)

- Physician services

- Custodial care or nonskilled care

- Services performed by a nonparticipating home health care provider

Home Infusion Therapy

This program provides coverage for home infusion therapy services whether or not you are confined to the home.

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

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care if the condition can be safely managed in the home

- Medically necessary

- Given by participating home infusion therapy providers

Services include:

- Drugs required for home infusion therapy

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

- Durable medical equipment, medical supplies and solutions needed for home infusion therapy

NOTE: Except for chemotherapeutic drugs, services provided for home infusion therapy under the home health care benefit are not covered separately elsewhere in your Plan.

We do not pay for services rendered by nonparticipating home infusion therapy providers.

Hospice Care Services

We pay for services for the terminally ill provided through a participating hospice program. To be payable, the following criteria must be met:

- The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.

- Certain certifications of terminally ill status are submitted to Blue Cross Blue Shield.

When hospice care is elected, certain home care services or hospice facility services and nursing care, physician services, medical social services, and counseling services become available, and the focus of care shifts primarily to care designed to maintain the comfort of the patient, relieve pain and suffering, and help the patient's family cope with the dying process. **A detailed description of the certifications required and the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

When hospice treatment is elected, the patient or his or her representative must sign a "Waiver of Benefits" form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient's (or family's) understanding that regular Blue Cross Blue Shield benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

NOTE: Blue Cross Blue Shield benefits for conditions <u>not</u> related to the terminal illness remain in effect.

Hospice care services may be canceled at any time by the patient or his or her representative. Simply submit a written statement to the hospice. When the services are canceled, regular coverage under your Plan will be reinstated.

Hospice care services that have been cancelled may be reinstated at any time. The patient is reinstated for any remaining period for which he or she is eligible.

Skilled Nursing Facility Services

We pay for skilled care in a Skilled Nursing Facility when ordered by the attending physician. We may require written confirmation of the need for skilled care from the attending physician. The facility must have a written agreement with Blue Cross Blue Shield to provide benefits under your Plan.

Services That Are Payable

- Payable services are:

  - Semi-private room, general nursing service, meals and special diets;
  - Special treatment rooms;
  - Routine laboratory examinations;
  - Physical, speech, or functional occupational therapy (when medically necessary);
  - Oxygen and other gas therapy;
  - Drugs, biologicals and solutions;
  - Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts;
  - Durable Medical Equipment used in the facility or outside when rented or purchased from the facility upon discharge;
  - Physician services (up to two visits per week).

Services are subject to a 100-day maximum per calendar year. We do not pay for custodial care.

Amounts that you pay for days in excess of the number covered under the Plan do not count toward the annual out-of-pocket maximum.

BlueHealthConnection Program

The BlueHealthConnection Program is a benefit under your Plan. It is an integrated health care management program that assists you in navigating the health care system and provides you with tools and information that you may use to make informed decisions about your health care and treatment options. It gives you access to:

- A nurse call center that is accessible by a toll-free telephone number 24 hours per day, seven days a week – **call 1-800-775-2583**

- Guided self-management tools such as Web-based information and, under certain circumstances, videos and a health directive handbook that allow Members to make decisions about their own health care

- Outreach programs for Members whose claims history indicates that telephone or mail contact with them may assist the Members' understanding and use of services available through BlueHealthConnection

- Integrated case and disease management, described below, for Members with a chronic illness like diabetes or heart disease or acute illness

- The Plan does not cover any services provided under the Provider Delivered Care Management Program under BlueHealthConnection

Integrated Case and Disease Management

Integrated case and disease management is a component of the BlueHealthConnection Program. It is a voluntary program designed to help manage the health care of Members with acute or chronic medical conditions, regardless of the setting. Under integrated case and disease management, we will pay for noncontractual services (services not ordinarily covered by the Plan) only when such services are specifically described in a signed treatment plan that has been approved by Blue Cross Blue Shield and/or the Trustees.

- Services described in the treatment plan will be provided only so long as the plan is in effect.
- Coverage for noncontractual services under integrated case and disease management will only be provided for the specific conditions identified in the treatment plan. Treatment of other conditions remains subject to the terms of your Plan.

Eligibility for Integrated Case and Disease Management

Blue Cross Blue Shield decides who is eligible for integrated case and disease management. Eligibility will be determined with reference to factors such as:

- Candidate's diagnosis
- Admission status
- Clinical status
- Scope of contractual benefits available to the candidate
- Availability of community services to the candidate and his or her family
- Personal and family support available to the candidate
- **Substantial probability of lasting improvement in the candidate's clinical status within 12 months**

Candidates for integrated case and disease management may be identified based on Blue Cross Blue Shield claims data. In addition, we will consider referrals of candidates from such sources as:

- Attending physicians
- Hospitals
- Candidate or candidate's family
- Administrative Manager or Board of Trustees

Termination of Integrated Case and Disease Management

Blue Cross Blue Shield may terminate the treatment plan and the Member's participation in integrated case and disease management if:

- The Member is no longer eligible to receive benefits under this Plan
- The Member voluntarily withdraws from the program

- The Member meets the treatment plan goals. (Termination in these cases occurs when the case manager determines that the goals have been met. As a result, termination may occur well before any expiration period described in the treatment plan is reached.)

- The Member fails to meet the treatment plan goals within the time period specified in the treatment plan

- The time period described in the Member's treatment plan expires

- The Member (or his or her representative), treating physician or case manager determines that the Member's participation in case management will no longer result in measurable improvement in the Member's clinical status

Services That Are Not Payable

We do not pay for any services provided by a relative of the Member.

Denials of claims for Integrated Case and Disease Management by Blue Cross Blue Shield can be appealed to the Board of Trustees. See **Filing Claims and Appeals.**

Alternative Facility Services That Are Not Payable

We do not pay for any services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.

How Hospitals, Facilities And Alternative To Hospital Care Providers Are Paid

Participating Providers

Almost all Michigan hospitals and many alternatives to hospital care providers participate with your Plan. Sometimes providers outside of Michigan participate with your Plan. The provider sends the claims to Blue Cross Blue Shield. Blue Cross Blue Shield will pay the approved amount directly to the provider.

- The provider accepts our payment as payment in full, less any Co-payments (and/or Co-insurance under Standard Coverage) or Deductible you are required to pay.

- You do not need to pay any amount beyond Co-payments (and/or Co-insurance under Standard Coverage) that apply to medically necessary services covered by your Plan (except in the limited cases described below).

- Even if the participating provider's charge for a covered service is more than our payment, you will not need to pay the difference.

- A participating provider has agreed not to charge you for services not covered by your Plan, if Blue Cross Blue Shield determines the service is not medically necessary (this determination is made through Blue Cross Blue Shield's audit process).

If you need to know if a provider participates, ask your doctor, the provider's admitting staff, or call your local customer service representative. (Use the numbers listed in the "How to Reach Blue Cross Blue Shield " section at the end of this SPD.) A copy of the listing of participating providers is provided automatically to each Member with this Summary Plan Description, at no charge, and additional free copies are available upon request.

Nonparticipating Providers

If you go to a nonparticipating hospital, facility or alternative to hospital care provider, you will need to pay most of the charges yourself. Your bill could be substantial. To receive payment for covered services (less any Co-payments (and/or co-insurance under Standard Coverage) you are required to pay) you will need to send Blue Cross Blue Shield a claim.

Nonparticipating provider charges are eligible for reimbursement from the Miscellaneous Benefit and the Individual HRA Plan. **Note that if you use your Benefit Advisor Card to pay a non-participating provider, your Individual HRA Account will be used to pay the bill. The only way to use Miscellaneous Benefits for a non-participating provider is to manually submit your claim to the Fund Office.**

(Call your customer service representative for information on filing claims. See **How to Reach Blue Cross Blue Shield**.)

- **The Plan does not pay for services provided by any of the following providers when they are nonparticipating providers:**

  - outpatient physical therapy facilities,
  - freestanding ambulatory surgery facilities,
  - skilled nursing facilities,
  - hospice programs,
  - long-term acute care facilities,
  - home health care agencies, or
  - home infusion therapy providers.

Except as provided below **Blue Cross Blue Shield coverage at other nonparticipating hospitals and facilities, both in and out of Michigan, is limited to services needed to treat an accidental injury or medical emergency.** We do not pay for nonemergency services in a nonparticipating hospital or facility, except as provided in this Section. The following explains your coverage when provided by a nonparticipating hospital or facility.

Emergency Services at a Nonparticipating Hospital

We will pay our approved amount, less any Co-payment you are required to pay under the Plan, for **emergency services** provided by an **accredited nonparticipating hospital or facility:**

- Located in an area not served by another Blue Cross and/or Blue Shield Plan; or

- Located in Michigan but not participating with another Blue Cross and/or Blue Shield Plan; or

- Participating with another Blue Cross and/or Blue Shield Plan, regardless of the facility's location.

Services That You Must Pay

You are required to pay for the following services:

- Services that are not included in your Plan

- Services that are not medically necessary **if** you agree to receive them after being advised by hospital staff that they will not be covered and you agree in advance **and** in writing to pay for them

In some cases, you **are required** to pay for services that **are medically necessary**. These limited cases are:

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

- When you fail to provide the hospital with information to identify your coverage

Out-of-State Providers

- An out-of-state provider may require you to pay for services at the time they are provided. If so, submit an itemized statement to Blue Cross Blue Shield for the services. Blue Cross Blue Shield will pay the approved amount to you.

- An out-of-state provider may submit a claim. If so, Blue Cross Blue Shield will pay the approved amount to the provider.

BlueCard Program

Blue Cross Blue Shield has arrangements with certain Blue Cross Blue Shield systems in other states that allow you to receive covered services when you are outside of Blue Cross Blue Shield's coverage area. This is called the **BlueCard Program**. If you receive covered services in another state from a BlueCard participating provider, the Host Plan will pay the provider the amount required under its contract with the provider less any Deductible, Co-payment or Co-insurance required under your Plan. After the Host Plan pays the provider, Blue Cross Blue Shield reimburses the Host Plan the amount required under the BlueCard Program.

If the provider is not a BlueCard participating provider, we will pay for out-of-state services as described above.

Your deductible, co-payment and co-insurance for services received outside of Michigan will be calculated using the designated payment level.

NOTE: Your deductible, co-payment and co-insurance requirements are based on your Plan and remain the same regardless of which Host Plan processes your claim for services.

The BlueCard Program will not apply if:

- The services are not a benefit under your Plan

- The Plan excludes coverage for services performed outside of Michigan or

- The services are performed by a vendor or provider who has a contract with Blue Cross Blue Shield for those services

Special Temporary Nonparticipating Hospital Coverage

If a participating hospital terminates its participating contract with Blue Cross Blue Shield, members may have difficulty obtaining certain services from participating hospitals. Under limited circumstances, the Plan provides temporary benefits for designated services, emergency care, and travel, meals, and lodging as described below from certain out-of-area hospitals and noncontracted area hospitals that are not participating hospitals. **These temporary benefits are provided only for certain specified services and only during the six-month period following the date a noncontracted area hospital terminated its participating contract with Blue Cross Blue Shield.**

A detailed description of the services and supplies that are payable under these circumstances is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Preapproval of special temporary nonparticipating hospital coverage services (except emergency care or ambulance services) must be obtained from Blue Cross Blue Shield before we will consider them for payment. If the required preapproval is not obtained, you must pay for these services.

Blue Cross Blue Shield customer service representatives can provide you and your physician with the telephone number to call for preapproval (see the **How to Reach Blue Cross Blue Shield** section at the end of this SPD). If the request for preapproval relates to a bone marrow transplant or an organ transplant, please ask your customer service representative for the telephone number of the Human Organ Transplant Program.

NOTE: Preapproval of services is not a guarantee that a claim for them will be paid. All claims are subject to a review of the reported diagnosis, medical necessity verification, the availability of benefits at the time the claim is processed as well as the requirements, conditions, limitations, exclusions, maximums, Deductibles, Co-payments and Co-insurance under your Plan.

Preapproval of special temporary nonparticipating hospital coverage services must be obtained as follows:

- Designated Services

Designated services are services that Blue Cross Blue Shield determines only a noncontracted area hospital can provide. Your physician must obtain preapproval for designated services by calling Blue Cross Blue Shield. If preapproval is not obtained, the designated services you receive will not be covered and you will be responsible for the hospital's charges.

- Travel, Meals and Lodging

You must obtain preapproval for any travel, meals and lodging expenses before they are incurred. If you do not obtain preapproval, travel, meals and lodging will not be covered and you will be responsible for these costs. Please call Blue Cross Blue Shield to obtain preapproval.

When Special Temporary Nonparticipating Hospital Coverage Benefits End

The benefits for special temporary nonparticipating hospital coverage are temporary. They will end six months from the date a noncontracted hospital terminated its participating contract with Blue Cross Blue Shield.

Coverage For Physician And Other Professional Provider Services

This section describes physician and other professional provider services covered by your Plan. It tells you:

- **Physician** And **Other Professional Provider Services That Are Payable**
- **Physician And Other Professional Provider Services That Are Not Payable**
- **How Physician And Other Professional Provider Services Are Paid**
- **Participating Providers**
- **Nonparticipating Providers**
- **Out-of-State Providers**
- **BlueCard Program**

Physician And Other Professional Provider Services That Are Payable

Except as provided under "Preventive Care," in order to be paid, services must be medically necessary and provided by persons who are legally qualified or licensed to provide them.

- **We pay our approved amount for the services described in this section (cost-sharing information is in "What You Must Pay"). These pages explain the extent to which the service is covered.**

    - Surgery
    - Presurgical Consultation
    - Anesthetics
    - Technical Surgical Assistance
    - Obstetrics
    - Newborn Examination
    - Inpatient Medical Care
    - Inpatient Mental Health Care
    - Outpatient Mental Health Care
    - Residential and Outpatient Substance Use Disorder Treatment
    - Inpatient Consultations
    - Emergency Treatment
    - Chemotherapy
    - End Stage Renal Disease (ESRD)
    - Therapeutic Radiology
    - Diagnostic Radiology
    - Diagnostic Services
    - Diagnostic Laboratory and Pathology Services
    - Allergy Testing and Therapy
    - Chiropractic Services
    - Physical, Speech and Language Pathology and Occupational Therapy Services
    - Office, Outpatient and Home Medical Care Visit
    - Cardiac Rehabilitation
    - Optometrist Services

Surgery

- Payment includes:

    - Physician's surgical fee
    - Medical care provided by the surgeon before and after surgery while the patient is in the hospital
    - Visits to the attending physician for the usual care before and after surgery

Multiple Surgeries

Multiple surgeries performed on the same day by the same physician are paid according to national standards recognized by Blue Cross Blue Shield.

Restrictions

- Dental surgery is payable **only** under limited circumstances stated in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.

- Surgery for gender reassignment is payable **only** for reconstructive procedures of the genitalia. Surgical procedures involving the face, vocal cords, breasts, abdomen, hips or other nongenital areas are not payable.

- Cosmetic surgery is payable **only** for:

    - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
    - Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
    - Conditions caused by accidental injuries
    - Traumatic scars

NOTE: Physician services for cosmetic surgery are **not payable** when services are primarily performed to improve appearance.

Presurgical Consultation

When your physician recommends surgery, you have the option of having a presurgical consultation with another physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon**.

You may obtain presurgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under your Plan.

You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:

- Second opinion - a consultation to confirm the need for surgery
- Third opinion - allowed if the second opinion differs from the initial proposal for surgery
- Nonsurgical opinion - given to determine your medical tolerance for the proposed surgery

Deductibles, Co-payments and Co-insurance required under your Plan do not apply to any of the three presurgical consultations listed above if they are obtained from participating physicians.

Anesthetics

For surgery

Services for giving anesthetics to patients undergoing covered surgery are payable to either:

- A physician other than the operating physician
- A physician who orders and supervises anesthesiology services
- A certified registered nurse anesthetist (CRNA) in an
    - Inpatient hospital setting
    - Outpatient hospital setting
    - Participating ambulatory surgery facility

CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

If the operating physician gives the anesthetics, the service is included in our payment for the surgery.

NOTE: Anesthesiology services performed by a qualified employee of a hospital or facility are not covered in this section of the Summary Plan Description. (See **Inpatient Hospital Services That Are Payable**.)

For infusion therapy

We pay for local anesthetics only when needed as part of infusion therapy done in the physician's office.

Technical Surgical Assistance (TSA)

In some cases, an additional physician provides technical assistance to the surgeon. We pay the approved amount for TSA, provided according to Blue Cross Blue Shield guidelines, in a hospital inpatient or outpatient setting or in an ambulatory surgery facility. A list of covered TSA surgeries is available from your local customer service center.

We do not pay for TSA:

- When services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
- When services are provided in a location other than a hospital or ambulatory surgery facility

Obstetrics

Prenatal and postnatal services are payable, as are services provided by the physician attending the birth.

Certified Nurse Midwife

We pay the approved amount for the following services when provided by a Certified Nurse Midwife minus any applicable Co-payments:

- Normal vaginal delivery when provided in:
  - an inpatient hospital setting
  - a birthing center which is hospital affiliated, state licensed and accredited as defined and approved by Blue Cross Blue Shield.
- Pre-natal care
- Post-natal care, including a Papanicolau (PAP) smear during the six-week visit.

Newborn Examination

A newborn's first routine physical exam is payable when provided during the mother's inpatient hospital stay. A doctor other than the anesthesiologist or the mother's attending physician must provide the exam.

NOTE: The baby must be eligible for coverage and must be added to your contract within 30 days of the birth. Ask the Fund Office or call Blue Cross Blue Shield.

Inpatient Medical Care

We pay for medical care by your attending physician while you are receiving inpatient services.

Inpatient Mental Health Care

We pay for the following inpatient mental health services when provided by a physician:

- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Psychological testing

- Electroshock therapy and its related anesthetics

- Inpatient consultations when your physician requires assistance in diagnosing or treating your mental health condition, when the assistance is required because of the special skill or knowledge of the consulting psychologist.

The following are covered for inpatient services performed by fully licensed psychologists with hospital privileges:

- Psychological testing

- Individual psychotherapeutic treatment

- Family counseling for members of a patient's family

- Group psychotherapeutic treatment

- Inpatient consultations when your physician requires assistance in diagnosing or treating your mental health condition, when the assistance is required because of the special skill or knowledge of the consulting psychologist

We do not pay for:

- Staff consultations required by a facility or program's rules

- Marital counseling (although family counseling for a spouse of a patient is covered)

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

Outpatient Mental Health Care

Unless otherwise specified, we pay for the outpatient mental health services listed below when provided by a physician or fully-licensed psychologist in an office setting or in a participating outpatient mental health facility. (See **Outpatient Mental Health Facility Services** in **Coverage for Hospital, Facility and Alternatives to Hospital Care** for a description of when these services are payable.)

- Individual psychotherapeutic treatment of less than 20 minutes provided in a participating outpatient mental health facility

- Individual psychotherapeutic treatment of more than 20 minutes

- Family counseling for members of a patient's family

- Group psychotherapeutic treatment

- Psychological testing by:

    - A physician or a fully-licensed psychologist or
    - A limited-licensed psychologist when prescribed and performed under, and billed by, a physician or fully-licensed psychologist

We do not pay for:

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

- Services provided to an inpatient in a hospital, skilled nursing facility or residential substance use disorder treatment program, except as provided below.

- Marital counseling (but family counseling for the spouse of a patient is covered)

Residential and Outpatient Substance Use Disorder Treatment

We pay the approved amount for medical care by a physician for treatment of substance use disorder in residential and outpatient substance use disorder treatment programs.

We pay for the assistance of a consulting physician when you are in an approved residential substance use disorder treatment program if the physician in charge of your case requests the assistance because special skill or knowledge is required to diagnose or treat the condition.

We do not pay staff consultations required by a facility or program’s rules.

Inpatient Consultations

Inpatient consultations are payable when your physician requires assistance in diagnosing or treating your condition, if the assistance is required because of the special skill or knowledge of the consulting physician or professional provider.

NOTE: Outpatient and office consultations are payable as office visits.

We do not pay for staff consultations required by a facility or program's rules.

Emergency Treatment

Services of one or more physicians for the initial exam and treatment of a medical emergency or an accidental injury are payable. Follow-up care is not considered emergency treatment.

Chemotherapy

We pay our approved amount for chemotherapeutic drugs. To be payable the drugs must be:

- Ordered by a physician for the treatment of a specific type of malignant disease

- Provided as part of a chemotherapy program

- Approved by the Food and Drug Administration (FDA) for use in chemotherapy treatment

  NOTE: If the FDA has not approved the drug for the specific disease being treated, Blue Cross Blue Shield's Medical Policy staff determines the appropriateness of the drug for that disease by using the following criteria:

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

  We also pay for:

- Physician services to administer the chemotherapy drug, **except** those taken orally

- The chemotherapy drug administered in a medically approved manner

- Other FDA-approved drugs classified as:

    - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
    - Drugs used to enhance chemotherapeutic drugs
    - Drugs to prevent or treat the side effects of chemotherapy treatment

- Administration sets, refills and maintenance of implantable or portable pumps and ports

End Stage Renal Disease (ESRD)

Physician services are payable for the treatment of ESRD. Services may be provided in the hospital, a participating freestanding ESRD facility or in the home.

NOTE: Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration. **A detailed description of the services and supplies that are payable for ESRD is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Therapeutic Radiology

We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by the attending physician or by another physician, if prescribed by the attending physician.

Diagnostic Radiology

We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- X-rays

- Ultrasound

- Radioactive isotopes

- Computerized axial tomography (CAT) scans

- Magnetic resonance imaging (MRI) for specific diagnoses

- Positron emission tomography (PET) scans

NOTE: You may call Blue Cross Blue Shield for information about any restrictions.

The services must be provided by your physician or by another physician if prescribed by your physician.

NOTE: Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities. You or your physician may call us for a list of participating facilities.

We do not pay for:

- Miniature X-ray plates, chest fluoroscopies, screening services (except routine mammograms)

- Procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury except as provided under **Preventive Care** in **Coverage for Other Health Care Services.**

Diagnostic Services

We pay for diagnostic services used by a physician to diagnose disease, illness, pregnancy or injury.

- Physician services are payable for tests such as:
  - Thyroid function
  - Electrocardiogram (EKG)
  - Electroencephalogram (EEG)
  - Pulmonary function studies

- Physician and independent physical therapist services are payable for the following tests:
  - Electromyogram (EMG)
  - Nerve conduction

- We pay for EMG and nerve conduction tests performed by an independent physical therapist if ordered by a physician. The independent physical therapist must be certified by the American Board of Physical Therapy Specialties to perform these tests.

Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology services needed to diagnose a disease, illness, pregnancy or injury. In addition, we pay for laboratory and pathology services as provided under **Preventive Care** in **Coverage for Other Health Care Services.** The services must be provided by your physician or by another physician if prescribed by your physician.

- Standard office laboratory tests are payable when performed in a physician's office in connection with the medical care given at the time of the visit.

- Standard laboratory tests are tests that:
  - Blue Cross Blue Shield has identified as payable and
  - Are essential to the patient's care at the time of the visit (also referred to as "immediate results" tests)

- Non-standard laboratory tests (tests that Blue Cross Blue Shield has identified as payable and are not essential to the patient's care at the time of the visit) are payable only when prescribed by a physician and performed by an independent laboratory or outpatient hospital laboratory

Allergy Testing and Therapy

We pay for the following allergy testing and therapy services, performed by, or under the supervision of, a physician:

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

- Your Plan requires a 20 percent Co-payment for allergy testing and therapy.

We do not pay for:

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

Chiropractic Services

We pay for the following chiropractic spinal manipulative treatment (with a $30.00 co-pay per visit for Standard Coverage):

- Spinal manipulation to treat misaligned or displaced vertebrae of the spine, with a maximum of 38 visits per Member per year.
- Office visits:
  - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received services within 36 months.
  - For established patients, we pay for one office visit per year. An established patient is one who has received services within 36 months.
- Mechanical traction once per day when it is performed with chiropractic spinal manipulation.
- Radiological services when X-rays are medically necessary to treat the spinal misalignment

Physical, Speech and Language Pathology and Occupational Therapy Services

We pay for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation. These services must be prescribed and provided by the appropriate providers, and must be likely to result in specific improvement of the patient's condition.

A detailed description of the types of providers that are payable, the conditions that must be met, and the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Office, Outpatient and Home Medical Care Visits

We pay for office visits (including office consultations), outpatient and home medical care visits, therapeutic injections by a physician, medical eye exams, emergency care in a physician's office and urgent care. The services must be to examine, diagnose and treat any condition of disease, pregnancy (including prenatal and postnatal care) or injury, except as provided in **Preventive Care** under **Coverage for Other Health Care Services.**

NOTE: Under Enhanced Coverage, your Plan requires a 20 percent Co-payment for these services. Under Standard Coverage, your Plan requires a $30 per visit Co-pay for these services. You are not required to pay a Co-payment for presurgical consultations.

We do not pay for:

- Routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy, or injury, and except as provided in **Hearing Care** under **Coverage for Other Health Care Services.**

Certified Nurse Practitioner

We pay for covered services performed by a certified nurse practitioner when the services are provided in any location, except a hospital inpatient setting.

NOTE: Certified nurse practitioner services are payable subject to the Co-payment requirements for office visits (including office consultations), outpatient and home medical care visits, therapeutic injections, medical eye exams, emergency care in a physician's office and urgent care.

Cardiac Rehabilitation

We pay for intensive monitoring (EKGs) and/or supervision during exercise in a physician-directed clinic (one in which a physician is on-site).

Optometrist Services

We pay our approved amount for covered services performed by a licensed optometrist within the scope of his or her license.

- The medical and surgical services performed by the optometrist must be provided within the state of Michigan.
- The optometrist must be licensed in the state of Michigan and certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents.
- Services performed by the optometrist will be considered services obtained from a nonparticipating provider if the optometrist does not participate under Blue Cross Blue Shield's vision program.

We do not pay for routine eye refractions, **except** in connection with a medical diagnosis, pregnancy, or injury.

Physician and Other Provider Services That Are NOT Payable

We do not pay for the following services:

- Services covered under any other Blue Cross or Blue Shield plan or under any other health care benefits plan
- Screening services, except as provided in **Preventive Care** under **Coverage for Other Health Care Services.**
- Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed in **Surgery**, above.
- Health care services provided by persons who are not legally qualified or licensed to provide them
- Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization)
- Weight loss programs (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
- Prescription medicines provided by a pharmacy; see Section 10 for your separate non-Blue Cross Blue Shield Prescription Medicine Benefits
- Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

- Services, care, supplies or devices not prescribed by a physician
- Services provided during nonemergency medical transport
- Experimental treatment
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Hearing aids or services to examine, prepare, fit or obtain hearing aids except as provided in **Hearing Care** under **Coverage for Other Health Care Services**.
- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
- Hospital services, including services provided by hospital employees, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.
- Drugs, medical appliances, materials or supplies and blood transfusions, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.
- Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, **except** as provided in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.
- Self-treatment by a professional provider and services given to parents, siblings, spouse or children
- Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
- Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient’s endurance while exercising and management of risk factors are stable
- Infertility services that do not treat a medical condition, other than infertility. This can include services such as:
    - Sperm washing
    - Post-coital test
    - Monitoring of ovarian response to ovulatory stimulants
    - In vitro fertilization
    - Ovarian wedge resection or ovarian drilling
    - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
    - Diagnostic studies done for the sole purpose of infertility assessment
    - Any procedure done to enhance reproductive capacity or fertility
- The following services provided by a Certified Nurse Practitioner that are:
    - not covered by your Plan
    - performed when you are a hospital inpatient

  NOTE: You or your physician can call Blue Cross Blue Shield to determine if other proposed services are not covered benefits under your Plan.

How Physician And Other Professional Provider Services Are Paid

We pay the approved amount (reduced by your Co-payment (or Co-insurance under Standard Coverage)) for each medically necessary covered service. In addition, as provided in Preventive Care under Coverage for Other Health Care Services, we pay the approved amount for certain preventive care services.

Participating Providers

- The participating provider submits a claim to us for the services you receive.
- We pay the provider directly for the covered services.

A participating provider may bill you when:

- You receive a service not covered by your Plan
- You acknowledge that we will not pay for medically unnecessary services and you agree, in writing, before receiving the services, that you will pay
- We deny a claim from a participating provider that was submitted more than 180 days after the service because you did not furnish needed information

Nonparticipating Providers

You should expect to pay charges to a nonparticipating provider at the time you receive the services. You should then submit a claim to Blue Cross Blue Shield. If Blue Cross Blue Shield approves the claim, it will send payment to you.

Nonparticipating provider charges are eligible for reimbursement from the Miscellaneous Benefit and the Individual HRA Plan. **Note that if you use your Benefit Advisor Card to pay a non-participating provider, your Individual HRA will be used to pay the bill. The only way to use Miscellaneous Benefits for a non-participating provider is to manually submit your claim to the Fund Office.**

NOTE: Because nonparticipating providers often charge more than our maximum payment level, Blue Cross Blue Shield's payment may be less than the amount charged by the provider.

Nonparticipating providers, except independent physical therapists, **may** agree to participate on a per claim basis. This means that they will accept the approved amount as payment in full for a specific service. If so:

- The provider will submit a claim to Blue Cross Blue Shield
- Blue Cross Blue Shield will send payment to the nonparticipating provider

Out-of-State Providers

- An out-of-state provider may require you to pay for services at the time they are provided. If so, submit an itemized statement to Blue Cross Blue Shield for the services. Blue Cross Blue Shield will pay the approved amount to you.
- An out-of-state provider may submit a claim. If so, Blue Cross Blue Shield will pay the approved amount to the provider.

BlueCard Program

Blue Cross Blue Shield has arrangements with certain Blue Cross Blue Shield systems in other states that allow you to receive covered services when you are outside of Blue Cross Blue Shield's coverage area. This is called the BlueCard Program. If you receive covered services in another state from a BlueCard participating provider, the Host Plan will pay the provider the amount required under its contract with the provider less any Deductible, Co-payment or Co-insurance required under your Plan. After the Host Plan pays the provider, Blue Cross Blue Shield reimburses the Host Plan the amount required under the BlueCard Program.

If the provider is not a BlueCard participating provider, Blue Cross Blue Shield will pay for out-of-state services as described above.

If your Plan requires a Deductible, Co-payment, or Co-insurance, your payment for services received outside of Michigan will be calculated using the designated payment level.

NOTE: Your Deductible, Co-payment and Co-insurance requirements are based on your Plan and remain the same regardless of which Host Plan processes your claim for services.

The BlueCard Program will not apply if:

- The services are not a benefit under your Plan
- Your Plan excludes coverage for services performed outside of Michigan or
- The services are performed by a vendor or provider who has a contract with Blue Cross Blue Shield for those services

Coverage For Other Health Care Services

This section describes coverage for other health care services. The facility and professional services listed below are paid as described in "Coverage for Hospital, Facility and Alternatives to Hospital Care" and "Coverage for Physician and Other Professional Provider Services."

Preventive Care Services

Your Plan provides coverage for the following preventive care/screening services once per calendar year up to the Blue Cross Blue Shield approved amount without age limitation, with no Deductibles, Co-payments or Co-insurance:

- **Health Maintenance Exam**

This is a comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

- **Gynecological Examination**

Screening for Routine Laboratory and Radiology Services includes chemical profile, complete blood count or any of its components, urinalysis, chest x-ray, EKG and cholesterol testing

- **Immunizations**
- **Well-Baby/Well-Child Care Visits and Immunizations**

These are included within and not in addition to the annual Health Maintenance Exam indicated above as follows:

- 6 visits from birth through 12 months;
- 6 visits from 13- months through 23 months ;6 visits from 24 months through 35 months ;
- 2 visits from 36 months through 47 months ; and
- 1 visit beyond 47months under the health maintenance exam benefit

- **Prostate Specific Antigen (PSA) Test**
- **Mammogram**
- **Pap Smear and related Laboratory and Pathology Services**
- **Fecal Occult Blood Screening**
- **Flexible Sigmoidoscopy Exam**
- **Colonoscopy**

- Any medical Preventive Care Services mandated by PPACA and added effective the first day of the Plan Year based on the updated list of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and that are listed at http://www.uspreventiveservicestaskforce.org;

- Immunizations mandated by PPACA and added effective the first day of the Plan Year that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved that are listed at http://www.cdc.gov/vaccines/schedules/hcp/adult.html and http://www.cdc.gov/vaccines/hcp/child-adolescent.html;

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings mandated by PPACA and added effective the first day of the Plan Year that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and that are listed at http://www.uspreventiveservicestaskforce.org;

- With respect to women, such additional preventive care and screenings mandated by PPACA and added effective the first day of the Plan Year as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and that are listed at http://www.hrsa.gov/womenguidelines/.

Dental Care and Dental Appliances

This section describes dental care covered by the Basic Benefits part of your coverage. See **Section 23 for Delta Dental administered dental coverage**.

Emergency Dental Treatment

We pay our approved amount for treatment of accidental injuries. An accidental injury is defined as occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

We pay for emergency treatment within 24 hours of the accidental injury to relieve pain and discomfort.

We must preapprove any follow-up services**.** You must complete follow-up treatment within six months of the accidental injury unless Blue Cross Blue Shield determines that the Member's condition makes treatment within this time period impossible.

We do not pay for:

- Treatment that was previously paid as a result of an accident

- Through December 31, 2013, dental conditions existing before the accident; however, this provision does not apply to a pre-existing accidental injury to a patient if the treatment of the pre-existing accidental injury satisfies the emergency treatment and follow-up treatment requirements stated above.

- Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue

Services to treat temporomandibular joint dysfunction, except as provided in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.

Durable Medical Equipment

We pay Blue Cross Blue Shield's approved amount for rental or purchase of durable medical equipment when prescribed by a physician. This coverage is subject to a 10% co-payment with Enhanced Coverage and 20% co-insurance with Standard Coverage. We cover the same items covered by the Medicare Part B Program when the items meet the following guidelines:

- The prescription includes a description of the equipment and the reason for the need or the diagnosis.

- The physician writes a new prescription when the current prescription expires; otherwise, the Plan will stop payment on the current expiration date or 30 days after the date of the patient's death, whichever is earlier.

- The co-payment and co-insurance requirements do not apply to insulin pumps and related supplies.

NOTE: If the equipment is:

- Rented, we do not pay for the charges that exceed the purchase price

- Purchased, we will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

We do not pay for:

- Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats

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

- Comfort and convenience items, such as bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners

- Physician's equipment, such as stethoscopes

- Self-help devices not primarily medical in nature, such as sauna baths and elevators

- Experimental equipment

Prosthetic and Orthotic Devices

The Plan pays Blue Cross Blue Shield's approved amount for prosthetic and orthotic devices prescribed by a physician. This includes the cost of purchasing, replacing, obtaining, developing and fitting the basic device and any medically necessary special features. Repairs, limited to the cost of a new device, are also covered. The prescription must include a description of the equipment and the reason for the need or the diagnosis.

We generally cover external prosthetic and orthotic devices that are considered payable by Medicare Part B as of the date of purchase or rental.

In addition, we cover orthopedic shoes that are not attached to a medically necessary brace and non-rigid devices and supplies such as shoe inserts and supportive appliances for the feet that are not attached to a medically necessary brace.

To be covered, custom-made devices must be furnished by a provider that is fully accredited or, with Blue Cross Blue Shield approval, conditionally accredited by the American Board of Certification in Orthotics and Prosthetics, Inc. (ABC), or, with Blue Cross Blue Shield approval, a provider who is either an MD, DO, Orthopedist, Prosthetic provider, Doctor of Podiatric Medicine (DPM), or durable medical equipment (DME) provider. You can call Blue Cross Blue Shield to confirm a provider's status.

Devices and Services That Are Not Payable

Some prosthetic and orthotic devices and services are not covered under your Plan. These include:

- Spare prosthetic devices
- Routine maintenance of the prosthetic device
- Prosthetic devices that are experimental
- Hair prostheses such as wigs, hairpieces, hair implants, etc.

A more detailed description of the orthotic and prosthetic services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Hearing Care

Covered Services

Your Plan pays the approved amount to **participating providers** for:

- An audiometric examination that is performed by a participating physician-specialist, audiologist, or hearing aid dealer
- A hearing aid evaluation test and a conformity test prescribed by a physician and performed by a participating physician-specialist, audiologist, or hearing aid dealer
- A monaural or binaural hearing aid that meets Blue Cross Blue Shield requirements.

Limitations and Exclusions

We will pay for the audiometric examination, hearing aid evaluation, conformity tests and a hearing aid once every 36 months, up to a maximum of $5,000 for the hearing aid. We will consider providing additional hearing care benefits if a physician-specialist sends Blue Cross Blue Shield documentation of severe hearing loss that has occurred within 36 months. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

The Plan generally pays these covered services **only when obtained from participating providers. The Plan will not pay for hearing care services if they are provided by a Nonparticipating Provider.**

You must obtain a medical evaluation (sometimes called a medical clearance examination) performed by a physician-specialist before you receive your hearing aid.

Details of the hearing care services and supplies that are payable and additional restrictions and requirements are contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Medical Supplies

We pay for medical supplies and dressings to be used in your home for the treatment of a specific medical condition. We do not pay for prescription medications used outside of the hospital. See **Section 10, Miscellaneous Benefits and Prescription Medicine Benefits**, for the prescription medicine allowance administered by the Fund Office.

Medicare Supplemental Benefits

The Plan provides benefits for Members enrolled in Medicare for services that are normally covered by the Plan.

If the covered services are provided by a Medicare participating provider or another provider that has agreed to accept the Medicare approved amount as full payment, the Plan will pay the deductible and the co-insurance amounts required by Medicare minus any Deductible, Co-payment or Co-insurance that would be required under the Plan for the covered services. For these claims, the Plan and Medicare pay the provider.

For claims for services for which the provider has not agreed to accept the Medicare approved amount as payment in full, the Plan's payment will be based on the Medicare approved amount, or the Blue Cross Blue Shield approved amount, whichever is greater, minus the Medicare payment, and minus any applicable Deductible, Co-payment or Co-insurance that would be required under the Plan for the covered services. For these claims, Medicare and the Plan pay you, and you are responsible for paying the provider's charge. The provider may charge you more than the Medicare or Blue Cross Blue Shield approved amounts.

If Medicare does not pay for a covered service, either because you have used up the benefits Medicare will pay, or it is not a Medicare benefit, the Plan will pay for covered services as if you were not covered by Medicare, based on the Blue Cross Blue Shield approved amount.

Private Duty Nursing Services

The Plan pays Blue Cross Blue Shield's approved amount for skilled care given by a private duty nurse in your home or in a hospital if:

- The patient's medical condition requires 24-hour care
- The patient requires medically necessary skilled care for a portion of the 24-hour period
- The skilled care (for example, ventilator care) is given by a professional registered nurse or licensed practical nurse
- The skilled care is given in a hospital because the hospital lacks intensive or cardiac care units or has no space in such units
- The skilled care is provided by a nurse who is not related to, or living with, the patient

The Plan does not pay for custodial care.

NOTE: Private duty nurses may require you to pay for services at the time they are provided. Submit an itemized statement to Blue Cross Blue Shield for the services. **All progress notes must be submitted with the**

claim. The Plan will pay the approved amount to you. Amounts paid in excess of amounts covered under the Plan do not count toward the annual out-of-pocket maximum.

Professional Ambulance Services

The Plan pays for ambulance services to transport a patient up to 25 miles. The Plan will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient's condition. In either case, the following conditions must be met:

- The service must be medically necessary because transport by any other means would endanger the patient's health.

- The service must be to transport the patient to a hospital or to transfer the patient between a hospital and another treatment location.

  NOTE: When ambulance service is used only to **transfer** the patient, the attending physician must prescribe the transfer.

- The service must be provided in a qualified vehicle

- The fee must be only for the transportation of the patient

Outpatient Diabetes Management Program

BCBSM Card Diabetes Benefits

Diabetes management medication, equipment and supplies should be obtained by using the BCBSM Card, which will be accepted as full payment by participating pharmacies. These will not be charged to your Miscellaneous, Prescription or Individual HRA Accounts – they are covered 100% as a Basic Benefit. Do not use your Benefit Advisor Card to obtain coverage for diabetic medications or supplies. The BCBSM Card works at most major pharmacies.

When you use your BCBSM Card, the Plan pays 100% of BCBSM's approved amount for the following covered items, regardless of whether you have Enhanced Coverage or Standard Coverage:

- Blood glucose monitors

- Blood glucose monitors for the legally blind

- Test strips for glucose monitors

- Visual reading and urine test strips

- Lancets

- Spring-powered lancet devices

- Syringes

- Insulin

- Nonexperimental drugs to control blood sugar

  NOTE: Coverage for syringes, insulin and diabetic prescription drug benefits is provided even though the plan normally does not cover prescription drugs.

- Insulin pumps
- Medical supplies required for the use of an insulin pump
- Diabetes self-management training conducted in a group setting, whenever practicable, if:
    - Self-management training is considered medically necessary upon diagnosis by an MD or DO who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
    - Your MD or DO diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
- The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health. Contact the Fund Office if you need reimbursement forms to submit for this coverage.

Reimbursement of Certain Diabetic Medications through the Fund Office

If you have diabetes, there is one type of prescription medication for which you may obtain 100% reimbursement through the Fund Office as a Basic Benefit, rather than through your Prescription Medicine Benefits, Miscellaneous Benefits, or Individual HRA: if you have diabetes and require medication that is prescribed by a doctor of podiatric medicine, MD or DO that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes, you must provide proof that the medication was prescribed to treat a condition related to diabetes and submit it to the Fund Office.

Contact the Fund Office if you have any problems obtaining 100% coverage for any diabetes management related items.

Voluntary Sterilization

The Plan provides coverage for hospital and physician services relating to voluntary sterilization, whether medically necessary or not, following a 90 day waiting period. This waiting period does not apply to patients who are under 19 years of age.

Autism Disorders

Covered Autism Spectrum Disorders

We pay for the diagnosis and outpatient treatment of Autism Spectrum Disorders, including: Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified, as described below.

Covered Services

Diagnostic services must be provided by a licensed physician or a licensed psychologist and include: assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule.

> Note: Before applied behavior analysis services will be covered, a BCBSM-approved autism evaluation center must evaluate and diagnose the member as having one of the covered autism spectrum disorders.

Treatment includes the following evidence-based care if prescribed or ordered by a licensed physician or licensed psychologist for a member who has been diagnosed with one of the covered autism spectrum disorders:

- **Applied behavior analysis treatment.** It must be provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

  Note: Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

  - **Applied behavior analysis treatment** is covered subject to the following requirements:

    - **Treatment Plan** – Applied behavior analysis treatment must be included in a treatment plan recommended by a BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition. If requested by BCBSM, the cost of treatment review will be paid by BCBSM.

    - **Prior Authorization** – Applied behavior analysis treatment must be approved for payment through BCBSM's prior authorization process. If prior authorization is not obtained, rendered services will not be covered and the member will be responsible to pay for those services. Prior authorization is not required for any other covered autism services.

- **Behavioral health treatment.** It includes evidence-based counseling that must be provided or supervised by a licensed psychologist, so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

- **Psychiatric care.** It includes evidence-based direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.

- **Psychological care.** It includes evidence-based direct or consultative services provided by a psychologist licensed in the state where he/she practices.

  Note: Benefits for autism disorders are in addition to any psychiatric, psychological and non-applied behavior analysis benefits that may be available under the Plan.

- **Therapeutic care.** It includes evidence-based physical therapy, occupational therapy, speech and language pathology, or other care performed by a licensed certified speech therapist, occupational therapist, physical therapist or social worker. Therapeutic care also includes nutritional therapy performed by a physician and genetic testing as recommended in the treatment plan.

<u>Coverage Requirements</u>

All autism services and treatment must be:

- Medically necessary and appropriate

- Comprehensive and focused on managing and improving the symptoms directly related to a member's Autism Spectrum Disorder.

- Deemed safe and effective by BCBSM.

  Note: Services or treatments that are deemed experimental or investigational by BCBSM, such as applied behavior analysis treatment, are covered only when they are approved by BCBSM and included in a treatment plan recommended by the BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition.

Limitations and Exclusions

In addition to those listed in the Plan, the following limitations and exclusions apply:

- Benefits for applied behavior analysis treatment are limited to children through the age of 18. This age limitation does not apply to psychiatric, psychological, non-applied behavior analysis services and services to diagnose autism.

- All autism benefits including, but not limited to, medical-surgical services and/or behavioral health treatment covered under the Plan are subject to any hospital/medical deductibles and coinsurance requirements.

- Any treatment that is not a covered benefit by BCBSM, including, but not limited to, sensory integration therapy and chelation therapy will not be paid.

- Conditions such as Rett's Disorder and Childhood Disintegrative Disorder are not payable under the Plan.

- When a member is treated with approved services for covered autism disorders, coverage for the services under this autism benefit overrides certain exclusions in the Plan such as exclusion of:

    - Experimental treatment

    - Treatment of chronic, developmental or congenital conditions

    - Treatment of learning disabilities or inherited speech abnormalities

    - Treatment solely to improve cognition, concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought.

- All autism services performed in Michigan must be provided by providers who are registered with BCBSM as a participating or nonparticipating provider.

- All autism services performed outside of Michigan must be provided by providers that participate with its local Blue Cross/Blue Shield plan.

SECTION 9

MEDICAL COVERAGE GENERAL CONDITIONS, LIMITATIONS AND EXCLUSIONS

This section lists and explains certain general conditions, limitations and exclusions that apply to your Plan. These conditions may make a difference in how, where and when benefits are available to you.

Assignment

The services provided under your Plan are for your personal benefit and cannot be transferred or assigned. Any attempt to assign benefits under your Plan will automatically terminate all your rights under it. No right to payment from the Plan, claim or cause of action against the Plan may be assigned by you to any provider. The Plan will not pay any provider except under the terms of the Plan.

Care and Services That Are Not Payable – In General

The Plan does not pay for the following care and services:

- Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under the Plan
- Those available in a hospital maintained by the state or federal government, unless payment is required by law
- Those payable by government-sponsored health care programs, such as Medicare, for which a Member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- In addition, the Plan provides certain benefits for Members enrolled in Medicare as provided under **Coverage for Other Health Care Services** in **"Medicare Supplemental Benefits."**
- Any services not listed in this Summary Plan Description and the Benefit Schedule as being payable.

Changes in Your Family and Special Enrollment Rights for Members who are Actively at Work

If you are Actively at Work, you may add your Spouse and Children to your coverage after the date you initially become eligible based on the rules in the following provisions. If you are not Actively at Work but are covered as a retiree (Normal, Early or Disability), your Spouse and Children can be added to coverage only when you first become eligible for coverage. If they are not enrolled at that time, they cannot be added later.

The following provisions apply only when you are Actively at Work (a Member who is not disabled, who is not retired, and who is working under the jurisdiction of UA Local 190).

If you have a new Spouse or Child as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your Spouse and your Children. This requires you to complete an enrollment/change of status form. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If you meet the 30-day deadline, coverage will take effect as of the date of the marriage, birth, adoption or placement for adoption. You also should notify the Administrative Manager of any divorce, death, address changes or the start of military service.

In addition, if you are declining enrollment for yourself, your Spouse or your Children because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Spouse and Children in this plan if you, your Spouse or your Children lost eligibility for that other coverage (or if an employer stops contributing towards your, your Spouse's or your Children's other coverage). However, you must request enrollment within 30 days after your, your Spouse's or your Children's other coverage ends (or after an employer

stops contributing toward the other coverage). If you meet the 30-day deadline, coverage will take effect as of the date of the loss or change in cost of the coverage. To request special enrollment or obtain more information, contact the Administrative Manager.

If you and/or your Spouse and/or your Children are eligible but not enrolled for coverage under this Plan, you may be able to enroll yourself and/or your Spouse and/or your Children this Plan under the following circumstances:

- You and/or your Spouse and/or your Children lose Medicaid or state Child Health Insurance Program coverage because you and/or your Spouse and/or your Children become ineligible for Medicaid or state Child Health Insurance Program coverage, or

- You and/or your Spouse and/or your Children become eligible for a premium assistance subsidy under Medicaid or a state Child Health Insurance Program.

You must request enrollment within 60 days of either of the above events in order to enroll under this Plan. If you meet this deadline, coverage will take effect as of the date of loss of Medicaid or state Child Health Insurance Program coverage.

The Plan must be notified within 30 days of any changes in your family if you want the change to relate back to the date of your change in circumstances.. This requires you to complete an enrollment/change of status form within the required time period. Your coverage changes will then take effect as of the date of the event. Changes include marriage, divorce, death, birth, adoption, address changes or the start of military service. **Except as otherwise provided above, if you fail to enroll a Spouse or Child or fail to notify the Administrative Manager of an eligible Spouse or Child within 30 days of a Spouse or Child becoming eligible, the Spouse or Child will not have coverage before the first day of the month following the date you file a satisfactorily completed enrollment/change of status form or Member Application for coverage for the Spouse or Child.**

Changes to Your Plan

Blue Cross Blue Shield employees, agents or representatives cannot agree to change or add to the benefits described in this Summary Plan Description.

- **Any changes must** be **in writing and approved by the Plan Trustees. The Trustees reserve the right to change or terminate benefits under the Plan at any time.**

- The Plan documents may add, limit, delete or clarify benefits.

Coordination of Benefits

The Plan coordinates the benefits payable under the Plan pursuant to the Michigan Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under the Plan are also covered and payable under another group health care plan, the Plan combines its payment with that of the other plan to pay the maximum amount it routinely pays for the covered services. See **Section 22, Coordination of Benefits and Subrogation**.

Coverage for Drugs and Devices

The Plan does not pay for any drug or device prescribed for uses or in dosages other than those specifically approved by the Food and Drug Administration. (This is often referred to as the off-label use of a drug or device.) However, the Plan will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing MD or DO can substantiate that the drug is recognized for treatment of the condition for which it is prescribed by one of the following:

- The American Medical Association Drug Evaluations

- The American Hospital Formulary Service Drug Information

- The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”

- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

  NOTE: Chemotherapeutic drugs are not subject to this general condition.

Deductibles, Co-insurance and Co-payments Paid Under Other Plans

The Plan does not pay deductibles, co-insurance or co-payments that you were required to pay under any other Plan.

Experimental Treatment

Services That Are Not Payable

The Plan does not pay for experimental treatment (including experimental drugs or devices) or services related to experimental treatment, except as explained under “Services That Are Payable" below. In addition, the Plan does not pay for administrative costs related to experimental treatment or for research management.

NOTE: The Plan does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

- The Blue Cross Blue Shield medical director is responsible for determining whether the use of any service is experimental. **The criteria that are used are explained in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.**

Services That Are Payable

The Plan does pay for experimental treatment and services related to experimental treatment when **all** of the following are met:

- Blue Cross Blue Shield considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).

- The treatment is covered under your Plan when it is provided as conventional treatment.

- The services related to the experimental treatment are covered under your Plan when they are related to conventional treatment.

- The experimental treatment and related services are provided during a Blue Cross Blue Shield-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by Blue Cross Blue Shield).

  NOTE: The Plan does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

- This section of the Summary Plan Description does not provide coverage for services not otherwise covered under your Plan.

- Drugs or devices provided to you during a Blue Cross Blue Shield -approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the Member's condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

Illness or Injuries Resulting from War

Services are not payable for the treatment of illness or injuries resulting from declared or undeclared military acts of war.

Improper Use of Plan Benefits

If you or any Spouse or Child allow any ineligible person to receive benefits (or try to receive benefits) under your Plan, or allow any eligible person to receive more than they are entitled to receive from the Plan, the Plan may take any of the following actions against you or your Spouse or Children:

- Refuse to pay benefits
- Cancel coverage
- Begin legal action
- Refuse to cover health care services at a later date
- Withhold benefit payments owed for services received by you, your Spouse or Children to recover the cost of benefits that should not have been paid, requiring you to pay your own medical costs.

Motor Vehicle Accident Injury Exclusion

The Plan will not cover services to treat an injury or condition that is a direct or indirect result of a motor vehicle accident under any circumstances.

A motor vehicle is considered a wheeled vehicle designed for operation on public roads or highways that is powered by something other than muscular power. Motor vehicle may include, but is not limited to, a car, truck, van, bus, semi-truck, trailer and/or motorcycle. A motor vehicle accident is an incident, loss, or damaging event involving the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle regardless of whether the accident also involves another object, structure, person, motor vehicle or non-motorized vehicle.

Some motor vehicle insurance (for example, motorcycle insurance) does not provide coverage for medical costs unless you request and pay for extra coverage. You should make sure you have motor vehicle medical expense coverage, because the Plan will not pay any claims that are the result of a motor vehicle accident.

Notification

When Blue Cross Blue Shield needs to notify you, the Plan mails the notice to your most recent address the Plan has in its records. This fulfills the Plan's obligation to notify you.

Other Coverage

In certain cases, we may have paid for health care services under your Plan that another person, insurance company or organization should have paid. In these cases, we have the right to recover payments you receive from someone else (a third party) to compensate you for your injury or illness, up to the amount the Plan paid relating to the illness or injury. We can recover these amounts no matter how the money you receive is characterized, even if

what you receive is described as not relating to medical expenses, and even if you only receive a partial recovery of what you claimed to be owed. See **Section 22, Coordination of Benefits and Subrogation**.

Payment of Covered Services

The covered services described in this Summary Plan Description, such as multiple surgeries or a series of services such as laboratory tests, are combined and paid according to payment policies adopted by Blue Cross Blue Shield.

Personal Costs

The Plan will not pay for:

- Transportation and travel, even if prescribed by a physician, except as provided under the Plan
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Physician of Choice

You may continue to receive services from the physician of your choice. The rules about participating providers do not prohibit you from seeing whatever physician you want to see. They only affect the amount we will pay.

Refunds of Premium

If the Plan determines that it must refund a self-pay or COBRA premium, it will refund up to a maximum of two years of payments.

Release of Information

You agree to permit providers to release information to Blue Cross Blue Shield and the Plan. This can include medical records and claims information related to services you may receive or have received.

Blue Cross Blue Shield and the Plan agree to keep this information confidential. Consistent with Blue Cross Blue Shield's and the Plan's Notices of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

Verbal verification of a Member's eligibility for coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, medical necessity verification, the availability of benefits at the time the claim is processed as well as to the conditions, limitations, exclusions, maximums and Co-payments under your coverage as stated in the official plan documents.

Right to Interpret Plan

During claims processing and internal grievances, the Plan reserves the right to interpret and administer the terms of the Plan and any amendments to the Plan. The Plan Administrator has full discretion to interpret the Plan Document when determining your rights. The Plan Administrator's final adverse decisions regarding claims processing and grievances are subject to your right to appeal under applicable law. See Section 21, Filing Claims and Appeals, for the claims and appeal procedures.

Semiprivate Room Availability

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you will be responsible for any additional cost. The Plan will not pay the difference between the cost of hospital rooms covered by your Plan and more expensive rooms.

Services Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this Summary Plan Description, the Plan will not pay for any services, treatment, care or supplies provided before your coverage under the Plan becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at a facility, the Plan's payment will be based on the facility's contract with Blue Cross Blue Shield. The Plan's 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 Plan coverage or after it ends.

Time Limit for Legal Action

Legal action against Blue Cross Blue Shield or the Plan may not begin later than two years after it has received a complete claim for services. No action or lawsuit may be started until after you have completely exhausted the claims review procedure. See **Section 21, Filing Claims and Appeals.**

Unlicensed Provider

Benefits are not payable for health care services provided by persons who are not legally qualified or licensed to provide such services.

Waiting Periods

There is a waiting period of 90 days for tonsillectomies and adenoidectomies and for voluntary sterilizations. The waiting period does not apply to patients who are under 19 years of age. See the Summary Plan Description. There is no waiting period for the treatment of pre-existing conditions effective January 1, 2014.

What Laws Apply

The Plan will be interpreted under the laws of the state of Michigan and the federal law known as "ERISA" (the Employee Retirement Income Security Act of 1974, as amended).

Workers Compensation

The Plan does not pay for the treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer.

Miscellaneous Exclusions

Your Basic Benefits are subject to the exclusions and limitations listed below. Most of these are listed elsewhere in this SPD. If not, then these are in addition to limitations listed elsewhere in this SPD.

If you are denied coverage for any reason, please contact the Administrative Manager's Office.

The following benefits are not Basic Benefits:

Inpatient Hospital Services That Are Not Payable

- Services that may be medically necessary but can be provided safely in an outpatient or office location
- Services of physicians and surgeons not employed by the hospital (see **Coverage for Physician and Other Professional Provider Services**)
- Custodial care or rest therapy
- Psychological tests if used as part of, or in connection with, vocational guidance training or vocational counseling
- Human organ transplants, except those specifically listed in this Summary Plan Description.
- Dental services. However, certain procedures may be payable as medical services if performed in a hospital because the patient has a dental condition that is adversely affecting medical condition under circumstances specified in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.
- Services covered under any other health care benefits plan
- Artificial and endodontic implants and related services, including repair and maintenance of implants and surrounding tissue

Hospital Admissions That Are Not Payable

- Those for care that is not considered acute, such as:
    - Observation
    - Dental treatment, including extraction of teeth, except as otherwise noted in this Summary Plan Description
    - Diagnostic evaluations
    - Lab exams
    - Electrocardiography
    - Weight reduction (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
    - X-rays, exams or therapy
    - Cobalt or ultrasound studies
    - Basal metabolism tests
    - Convalescence or rest care
    - Convenience
- Those mainly for physical therapy, speech and language pathology services or occupational therapy

Outpatient Hospital Services That Are Not Payable

The services listed under "Inpatient Hospital Services That Are Not Payable" are also not payable when provided as outpatient care. In addition, we do not pay for:

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

Mental Health Services That Are Not Payable

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Marital counseling (but family counseling is available to the Spouse of a patient receiving counseling)

Substance Use Disorder Treatment Services Not Payable

- Services provided primarily for a diagnosis other than substance use disorder
- Dispensing methadone or testing urine specimens, unless you are receiving therapy, counseling or psychological testing
- Diversional therapy
- Services provided beyond the period necessary for care and treatment
- Services provided during the portion of any residential admission that occurs before the effective date of this Plan

Other Services That Are Not Payable

- Services by a nonparticipating ambulatory surgery facility
- Physical therapy, speech and language pathology services, and occupational therapy services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance use disorder treatment program
- Physical therapy, speech and language pathology services, and occupational therapy services provided to you in the home
- Services provided by a nonparticipating end stage renal disease facility
- Services not provided by the employees of the ESRD facility
- Freestanding ESRD facility services not related to the dialysis process
- Services in a nonparticipating long-term acute care hospital including emergency services
- Inpatient long-term acute care hospital admissions that Blue Cross Blue Shield has not preapproved
- Out-of-state long-term acute care hospital admissions, except with special approval from the Administrative Manager
- Home health care provider general housekeeping services
- Home health care provider transportation to and from a hospital or other facility
- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.) provided by a home health care provider
- Home health care provider custodial care or nonskilled care
- Services performed by a nonparticipating home health care provider

- Services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.

- Services provided by any of the following providers when they are nonparticipating providers:

    - outpatient physical therapy facilities,
    - freestanding ambulatory surgery facilities,
    - skilled nursing facilities,
    - hospice programs,
    - long-term acute care facilities,
    - home health care agencies,
    - home infusion therapy providers

- Services at a nonparticipating hospital or facility other than those needed to treat an accidental injury or medical emergency

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

- Screening services, except as provided in **Preventive Care** under **Coverage for Other Health Care Services.**

- Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed in **Surgery**, above.

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

- Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization)

- Weight loss programs (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)

    Prescription medicines provided by a pharmacy; see Section 10 for your separate non-Blue Cross Blue Shield Prescription Medicine Benefits

- Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

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

- Services provided during nonemergency medical transport

- Experimental treatment

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

- Hearing aids or services to examine, prepare, fit or obtain hearing aids except as provided in **Hearing Care** under **Coverage for Other Health Care Services**.

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

- Hospital services, including services provided by hospital employees, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.

- Drugs, medical appliances, materials or supplies and blood transfusions, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.

- Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, **except** as provided in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.

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

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

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

- Infertility services that do not treat a medical condition, other than infertility. This can include services such as:

    - Sperm washing
    - Post-coital test
    - Monitoring of ovarian response to ovulatory stimulants
    - In vitro fertilization
    - Ovarian wedge resection or ovarian drilling
    - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
    - Diagnostic studies done for the sole purpose of infertility assessment
    - Any procedure done to enhance reproductive capacity or fertility

- The following services provided by a Certified Nurse Practitioner:

    - Services not covered by your Plan
    - Services performed when you are a hospital inpatient

- Reversal of sterilization procedures.

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

- Psychological tests for vocational guidance or vocational counseling.

- Care and services payable by government-sponsored health care programs, such as Medicare or CHAMPUS, for which a Participant is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs.

- Dialysis services after 30 months of ESRD treatment.

- Services that are not included in the certificate and riders that are part of the contract between the Plan and Blue Cross Blue Shield.

- Testing and treatment for sexual dysfunctions not related to organic disease.

NOTE: You or your physician can call Blue Cross Blue Shield to determine if other proposed services are not covered benefits under your Plan.

SECTION 10

MISCELLANEOUS BENEFITS AND PRESCRIPTION MEDICINE BENEFITS

What about items not covered by Basic Benefits administered by Blue Cross Blue Shield?

Basic Benefits are paid by the Fund to Blue Cross Blue Shield, which pays the providers of Basic Benefit services directly. Prescription medicines, vision expenses, dental expenses and other miscellaneous services are not part of Basic Benefits. Services and items not covered by Basic Benefits may be covered separately by the Fund through your Benefit Advisor Card or an arrangement that allows you to be reimbursed for expenses you pay yourself. You should use the Benefit Advisor Card to obtain Prescription Medicine Benefits (for which you should also use the Blue Cross Blue Shield of Michigan Card) and dental and vision Miscellaneous Benefits.

The Fund provides reimbursements up to certain limits for each active and retired Member: a Prescription Medicine Benefit for prescription medicine reimbursements, and a Miscellaneous Benefit for items and services that meet IRS requirements for medical coverage but are not covered by the Basic Benefits. For claims that are submitted manually (other than prescription claims) to be eligible for payment, all claims for reimbursements under these reimbursement funds must be submitted to the Fund Office by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued.

Prescription Medicine Benefit

What do I do if I need a prescription filled?

The Fund provides a Prescription Medicine Benefit separate from Blue Cross Blue Shield Basic Benefits. The maximum reimbursement for a year is $1,440. Unused amounts for one year do not carry forward to any later year. Amounts you pay in excess of $1,440 do not count toward the annual out-of-pocket maximum.

To get a prescription filled, go to your pharmacy and present your Blue Cross Blue Shield of Michigan Card and your Benefit Advisor Card. If the pharmacy does not accept VISA, or rejects the Benefit Advisor Card for any other reason**, you should still present and use the Blue Cross Blue Shield of Michigan Card**, and then submit the receipt to the Fund Office if you still have Prescription Medicine Benefits, Miscellaneous Benefits, or Individual HRA Benefits left for the year.

Prescriptions should be paid through use of both the Benefit Advisor Card and the Blue Cross Blue Shield of Michigan Card. Prescriptions purchased without the use of your Blue Cross Blue Shield of Michigan Card will not be counted towards the TrOOP annual out-of-pocket limit. The Blue Cross Blue Shield of Michigan Card approves your prescription for payment by this Plan. The Benefit Access Card then processes the payment from your available funds.

Remember that if you are a Medicare-Eligible Retiree, your prescription medicine costs will not count towards the TrOOP annual out-of-pocket limit.

How do I pay for diabetes medications and supplies?

You can use your Blue Cross Blue Shield of Michigan Card to pay for diabetes medications and supplies. **Your Benefit Advisor Card is not necessary.** By using the Blue Cross Blue Shield of Michigan Card, you obtain your diabetes-related medicines and supplies as a **Basic Benefit**. There is no limitation on the Prescription Medicine Benefit for diabetes-related medications and supplies.

What if I am eligible for Medicare Part D coverage?

For Medicare eligible Members, the Fund will reimburse eligible Medicare Part D coverage premiums (Medicare Part D coverage premiums that do not exceed the standard Medicare Part D premium amount for each month) from your available Prescription Medicine Account. Until further notice, the eligible Medicare Part D premium amount for each month is $36 per month. The total maximum Prescription reimbursement for the year, including Part D premiums, still will not exceed $1,440. If this limit is changed, the Administrative Manager will notify eligible Members.

The Administrative Manager will reserve the portion of Medicare Part D covered Members' annual limit needed to pay the eligible Medicare Part D premiums for the entire year to ensure that the maximum eligible Medicare Part D premiums will be covered. If a Member wishes to have the full limit applied to other eligible expenses, a written waiver can be signed and the remaining annual limit will be applied to other eligible expenses instead of being reserved for, and applied to, the remaining Medicare Part D premiums.

In addition, even though the Prescription Medicine Benefit normally does not reimburse deductibles, co-insurance or co-pays, for Medicare eligible Members, until further notice the Fund will reimburse a maximum of $310 of claims paid by the Member because of the Medicare Part D deductible. If this limit is changed, the Administrative Manager will notify eligible Members.

Effective January 1, 2014, the Medicare Part D co-pay is eligible for reimbursement by the Fund. This means that any prescription drug co-pay imposed by the Medicare prescription drug plan is eligible for reimbursement from the Prescription Medicine and Miscellaneous Benefits Accounts.

Example for a Member who is not eligible for Medicare: The Fund will reimburse $1,440 of Prescription Medicine Benefits expenses submitted for the year. **Example for a Medicare-eligible Member:** For a Medicare-eligible Member who gets reimbursed for the full $432 of eligible Medicare Part D premiums from Prescription Medicine Benefits ($36 per month for 12 months), the Fund would reimburse $1,008 of other eligible prescription expenses submitted for the year. The Administrative Manager will treat this Member as having only $1,008 of Prescription Medicine Benefits available for the year in order to reserve the full $432 of premiums ($36 per month) for the entire year. If the Member exceeded the $1,008 earlier in the year and wanted to apply the remainder of the Member's annual limit to eligible prescription costs, the reserve would become available once the Member signed a waiver form. **Note that the Benefit Advisor Card cannot be used to pay for Medicare Part D premiums**.

Miscellaneous Benefit

What do I do if I need a service not covered by the Blue Cross Blue Shield Basic Benefits or need additional prescriptions after using up the Prescription Benefit?

The Fund provides a separate **Miscellaneous Benefit** amount for each Participant. The maximum reimbursement for a year is $1,800 per family (Participant, Spouse and Children combined). Unused amounts for one year do not carry forward to any later year.

What expenses are eligible for reimbursement under Miscellaneous Benefits?

The Miscellaneous Benefit covers expenses (up to a total of $1,800) that meet the following criteria:

- The expense is the type of expense that would be eligible for the medical expense deduction on your U.S. Individual Income Tax Return (without taking into account the income percentage rules); and
- The expense is not an insurance premium, long-term care contract expense or premium, or long-term nursing home expense;
- If the expense is for vitamins, medicine or supplies other than insulin, it is covered only if prescribed by a physician for a specific disease or condition; and

- The expense would not be paid or covered by any health plan (other than the Fund), Workers' Compensation Insurance, automobile insurance, government or other source if the Miscellaneous Benefit did not exist.

- If the expense is for services, the expense is for services that have been rendered during the year or will be rendered during the current year. For example, the current year Miscellaneous Benefit cannot be used to pay for orthodontia services that will be rendered in later years.

- The Deductible, Co-pay and Co-insurance amounts that are not covered by Basic Benefits are not covered by Miscellaneous Benefits.

- The only exception to the "no insurance premium" rule is that any Medicare Part D insurance premiums that would be eligible for reimbursement under the Prescription Medicine Benefit are eligible for reimbursement under Miscellaneous Benefits after the Prescription Medicine Benefit maximum for the year has been used up.

- The 50% Delta Dental co-payment is covered by Miscellaneous Benefits

The medical expense deduction for income taxes allows deduction of a wide variety of medical expenses if they exceed a certain percentage of your income for the year. We ignore the IRS percentage of income rule - the percentage of income rule does not apply for purposes of the Miscellaneous Benefit. The Miscellaneous Benefit uses the IRS definition because it is the broadest possible benefit that can be paid to you tax-free. The expenses must be paid for the diagnosis, cure, mitigation (lessening), treatment, or prevention of a specific disease or for treatments affecting a specific part or function of the body. The expenses must be primarily to relieve or prevent a specific physical or mental defect or illness. Expenses that qualify and do not qualify for this deduction are listed and explained in IRS Publication 502. See the **selective excerpt from Publication 502** provided at the end of this section, which has been modified to fit this Plan.

The Plan Administrator will look to Publication 502 and other IRS guidance to determine what is and is not an eligible expense. However, determinations of this sort often require exercise of judgment and weighing of the facts of each particular situation. The Plan Administrator has broad discretion to make the determination of what is eligible within these guidelines, and the Plan Administrator's decision will be final and binding in all respects, subject to the usual claims appeal rights described in **Section 21, Filing Claims and Appeals**.

Some examples of expenses that are covered by the Miscellaneous Benefit if not covered elsewhere are: eye exams, corrective lenses, contacts, hearing care services and devices, dental expenses, oral surgery expenses, doctors' fees for office visits that do not meet the Blue Cross Blue Shield criteria, medically necessary items such as medical equipment rental and medical appliances that do not meet Blue Cross Blue Shield criteria, surgical and hospital expenses in excess of Basic Benefits, and your share of the cost of Basic Benefits provided by someone who is not a Blue Cross Blue Shield participating provider.

Will the Fund pay for expenses caused by an injury or illness sustained during employment?

No coverage is provided for illness or injury sustained during the course of any employment for wage or profit because these costs are covered by Workers' Compensation Insurance. This protects the Fund from expenses that are covered by or should have been claimed through the Workers' Compensation system.

How do I collect my Miscellaneous Benefits?

Miscellaneous Benefits will be paid through your Benefit Advisor Card. For expenses incurred with service providers that do not accept the Benefit Advisor Card for a qualifying expense, submit proof of the expense, such as a vision expense receipt or Explanation of Benefits from Blue Cross Blue Shield or Delta Dental or other written proof of the expense and its medical necessity to the Administrative Manager. Contact the Administrative Manager at the address or phone number listed at the end of this SPD if you have questions on what is needed to obtain reimbursement. The Fund Office will issue a check for the covered amount payable to you or, upon request, your medical provider if, after reviewing the claim, it is determined that the expense is an eligible expense and you have benefits available under the annual limit.

How do the Prescription Medicine Benefits, Miscellaneous Benefits and Individual HRA Benefits coordinate with each other under the Benefit Advisor Card?

Depending on the nature of the expense, the Benefit Advisor Card will deduct the expense from your account balances as follows:

- If the expense is a prescription and you use your Blue Cross Blue Shield of Michigan Card, it will first be deducted from your Prescription Medicine Benefits account, then from your Miscellaneous Benefits account and then from your Individual HRA account.

- If the expense is a dental or vision expense, or a prescription after your Prescription Medicine Benefits account has been used up, it will first be deducted from your Miscellaneous Benefits account, and then from your Individual HRA account.

- If the expense is incurred at a hospital or doctor's office, or other health care provider facility, or is a prescription, dental or vision expense and your Prescription Medicine Benefits account and Miscellaneous Benefits account are used up, it will be deducted from your Individual HRA account.

- When you use your Benefit Advisor Card for medical expenses other than vision, dental or prescription medicines, funds will be automatically taken from your Individual HRA account first, even if you still have amounts available under your Miscellaneous Benefits account. The card works this way because most items other than dental, vision or prescription expenses will be Deductibles, Co-payments or Co-insurance, all of which are only reimbursable from the Individual HRA. If you have a medical expense at a hospital or doctor's office that is not covered by Blue Cross Blue Shield, such as a non-participating provider expense, you can use Miscellaneous Benefit funds only by submitting the claim to the Fund Office. In effect, this means your Individual HRA account is now "primary" for miscellaneous medical expenses that are paid using the Benefit Advisor Card other than prescriptions, vision, or dental expenses. Your Miscellaneous Benefits account is "secondary" for medical expenses other than vision, dental or prescription medicine expenses when the Benefit Advisor Card is used, and if you have no Individual HRA balance left and have Miscellaneous Benefits left, you will need to manually submit those expenses to the Fund Office.

Selective Excerpts from IRS Publication 502

Following are examples of the types of expenses that can be reimbursed under the Miscellaneous Benefit. If you can include an expense in medical expenses under the following criteria, it is eligible for reimbursement under the Miscellaneous Benefit, subject to the limits and restrictions already explained above. Note that any reference to "dependent" or "dependents" in this section mean only a Spouse or Child as defined for purposes of this Plan.

Medical and Dental Expenses

What Medical Expenses Are Deductible?

Following is a list of items that you **can** include in figuring your medical expense deduction. The items are listed in alphabetical order.

Abortion

You can include in medical expenses the amount you pay for a legal abortion.

Acupuncture

You can include in medical expenses the amount you pay for acupuncture.

Alcoholism

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment. You can also include in medical expenses transportation costs you pay to attend meetings of an Alcoholics Anonymous Club in your community if your attendance is pursuant to medical advice that membership in the Alcoholics Anonymous Club is necessary for the treatment of a disease involving the excessive use of alcoholic liquors.

Ambulance

You can include in medical expenses amounts you pay for ambulance service.

Artificial Limb

You can include in medical expenses the amount you pay for an artificial limb.

Artificial Teeth

You can include in medical expenses the amount you pay for artificial teeth.

Autoette

See **Wheelchair**, later.

Birth Control Pills

You can include in medical expenses the amount you pay for birth control pills prescribed by a doctor.

Braille Books and Magazines

You can include in medical expenses the part of the cost of Braille books and magazines for use by a visually-impaired person that is more than the cost of regular printed editions.

Capital Expenses

You can include in medical expenses amounts you pay for special equipment installed in your home, or for improvements, if their main purpose is medical care for you, your spouse, or your child. The cost of permanent improvements that increase the value of the property may be partly included as a medical expense. The cost of the improvement is reduced by the increase in the value of the property. The difference is a medical expense. If the value of the property is not increased by the improvement, the entire cost is included as a medical expense.

Certain improvements made to accommodate your home to your disabled condition, or that of your Spouse or your Children who live with you, do not usually increase the value of the home and the cost can be included in full as medical expenses. These improvements include, but are not limited to, the following items.

- Constructing entrance or exit ramps for your home.
- Widening doorways at entrances or exits to your home.
- Widening or otherwise modifying hallways and interior doorways.
- Installing railings, support bars, or other modifications to bathrooms.
- Lowering or modifying kitchen cabinets and equipment.

- Moving or modifying electrical outlets and fixtures.
- Installing porch lifts and other forms of lifts but generally not elevators.
- Modifying fire alarms, smoke detectors, and other warning systems.
- Modifying stairways.
- Adding handrails or grab bars anywhere (whether or not in bathrooms).
- Modifying hardware on doors.
- Modifying areas in front of entrance and exit doorways.
- Grading the ground to provide access to the residence.

Only reasonable costs to accommodate a home to a disabled condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not medical expenses.

Example. You have a heart ailment. On your doctor's advice, you install an elevator in your home so that you will not have to climb stairs. The elevator costs $8,000. An appraisal shows that the elevator increases the value of your home by $4,400. You figure your medical expense like this:

$8,000 (cost) minus $4,400 (increase in value) = $3,600 (medical expense).

Operation and upkeep. Amounts you pay for operation and upkeep of a capital asset qualify as medical expenses, as long as the main reason for them is medical care. This is so even if none or only part of the original cost of the capital asset qualified as a medical care expense.

Example. If, in the previous example, the elevator increased the value of your home by $8,000, you would have no medical expense for the cost of the elevator. However, the cost of electricity to operate the elevator and any costs to maintain it are medical expenses as long as the medical reason for the elevator exists.

Improvements to property rented by a person with a disability. Amounts paid by a person with a disability to buy and install special plumbing fixtures, mainly for medical reasons, in a rented house are medical expenses.

Example. John has arthritis and a heart condition. He cannot climb stairs or get into a bathtub. On his doctor's advice, he installs a bathroom with a shower stall on the first floor of his two-story rented house. The landlord did not pay any of the cost of buying and installing the special plumbing and did not lower the rent. John can include in medical expenses the entire amount he paid.

Car

You can include in medical expenses the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.

- **Special design**. You can include in medical expenses the difference in the cost of a car specially designed to hold a wheelchair and a regular car.
- **Cost of operation**. You cannot deduct the cost of operating a specially equipped car, except as discussed under **Transportation**, later.

Chiropractor

You can include in medical expenses fees you pay to a chiropractor for medical care.

Christian Science Practitioner

You can include in medical expenses fees you pay to Christian Science practitioners for medical care.

Contact Lenses

You can include in medical expenses amounts you pay for contact lenses needed for medical reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner. See also **Eyeglasses** and **Laser Eye Surgery**, later.

Crutches

You can include in medical expenses the amount you pay to buy or rent crutches.

Dental Treatment

You can include in medical expenses the amounts you pay for dental treatment. This includes fees paid to dentists for X-rays, fillings, braces, extractions, dentures, etc.

Drug Addiction

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging at the center during treatment.

Drugs

See **Medicines**, later.

Eyeglasses

You can include in medical expenses amounts you pay for eyeglasses and contact lenses needed for medical reasons. You can also include fees paid for eye examinations.

Fertility Enhancement

You can include in medical expenses the cost of the following procedures to overcome your inability to have children.

- Procedures such as in vitro fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse prior surgery that prevents you from having children.

Guide Dog or other Animal

You can include in medical expenses the cost of a guide dog or other animal to be used by a visually impaired or hearing-impaired person. You can also include the cost of a dog or other animal trained to assist persons with other physical disabilities. Amounts you pay for the care of these specially trained animals are also medical expenses.

Health Institute

You can include in medical expenses fees you pay for treatment at a health institute only if a physician prescribes the treatment and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.

Hearing Aids

You can include in medical expenses the cost of a hearing aid and the batteries you buy to operate it.

Home Care

See **Nursing Services**, later.

Hospital Services

You can include in medical expenses amounts you pay for the cost of inpatient care at a hospital or similar institution if the main reason for being there is to receive medical care. This includes amounts paid for meals and lodging. Also see **Lodging**, later.

Laboratory Fees

You can include in medical expenses the amounts you pay for laboratory fees that are part of your medical care.

Laser Eye Surgery

You can include in medical expenses the amount you pay for surgery to improve vision, such as radial keratotomy or other laser eye surgery, if it is done primarily to promote the correct function of the eye.

Lead-Based Paint Removal

You can include in medical expenses the cost of removing lead-based paints from surfaces in your home to prevent a child who has or has had lead poisoning from eating the paint. These surfaces must be in poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area is not a medical expense.

If, instead of removing the paint, you cover the area with wallboard or paneling, treat these items as capital expenses. See **Capital Expenses**, earlier. Do not include the cost of painting the wallboard as a medical expense.

Learning Disability

You can include in medical expenses tuition fees you pay to a special school for a Child who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders. Your doctor must recommend that the Child attend the school. See **Schools and Education, Special**, later. You can also include tutoring fees you pay on your doctor's recommendation for the Child's tutoring by a teacher who is specially trained and qualified to work with children who have severe learning disabilities.

Legal Fees

You can include in medical expenses legal fees you paid that are necessary to authorize treatment for mental illness. However, you cannot include in medical expenses fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not necessary for medical care.

Lodging

You can include in medical expenses the cost of meals and lodging at a hospital or similar institution if your main reason for being there is to receive medical care. See **Nursing Home**, later.

You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. You can include the cost of such lodging while away from home if you meet all of the following requirements:

- The lodging is primarily for and essential to medical care.

- The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.

- The lodging is not lavish or extravagant under the circumstances.

- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount you include in medical expenses for lodging cannot be more than $50 for each night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included.

Do not include the cost of your lodging while you are away from home for medical treatment if you do not receive that treatment from a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital or if that lodging is not primarily for or essential to the medical care you are receiving.

Meals

You can include in medical expenses the cost of meals at a hospital or similar institution if the main purpose for being there is to get medical care. You cannot include in medical expenses the cost of meals that are not part of inpatient care.

Medical Conferences

You can include in medical expenses amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of you, your Spouse, or your Child. The costs of the medical conference must be primarily for and necessary to the medical care of you, your Spouse, or your Child. You must spend the majority of your time at the conference attending sessions on medical information.

The cost of meals and lodging while attending the conference is not deductible as a medical expense.

Medical Information Plan

You can include in medical expenses amounts paid to a plan that keeps your medical information so that it can be retrieved from a computer data bank for your medical care.

Medical Expenses

- You can include in medical expenses amounts that are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

- Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medicines

You can include in medical expenses amounts you pay for prescribed medicines and drugs. You can also include amounts you pay for insulin. Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed. (**Note that the 20% co-pay under the Prescription Medicine Benefit is not eligible for reimbursement as a Miscellaneous Benefit.)**

Controlled substances. You cannot include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.), in violation of federal law.

Mentally Retarded, Special Home for

You can include in medical expenses the cost of keeping a mentally retarded person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living.

Nursing Home

You can include in medical expenses the cost of medical care in a nursing home or home for the aged for yourself, your Spouse, or your Children. This includes the cost of meals and lodging in the home if the main reason for being there is to get medical care. Do not include the cost of meals and lodging if the reason for being in the home is personal. You can, however, include in medical expenses the part of the cost that is for medical or nursing care.

Nursing Services

You can include in medical expenses wages and other amounts you pay for nursing services. A nurse need not perform services as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided in your home or another care facility.

Generally, only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, these amounts must be divided between the time spent performing household and personal services and the time spent for nursing services. However, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. See **Long-Term Care Contracts, Qualified**, earlier. Additionally certain expenses for household services or for the care of a qualifying individual incurred to allow you to work may qualify for the child and dependent care credit. See **Publication 503, Child and Dependent Care Expenses**. You can also include in medical expenses part of the amount you pay for that attendant's meals. Divide the food expense among the household members to find the cost of the attendant's food. Then apportion that cost in the same manner, as in the preceding paragraph. If you had to pay additional amounts for household upkeep because of the attendant, you can include the extra amounts with your medical expenses. This includes extra rent or utilities you pay because you moved to a larger apartment to provide space for the attendant.

Employment taxes. You can include as a medical expense social security tax, FUTA, Medicare tax, and state employment taxes you pay for a nurse, attendant, or other person who provides medical care. For information on employment tax responsibilities of household employers, see **Publication 926, Household Employer's Tax Guide**.

Healthy baby. You cannot include the cost of nursing services for a normal, healthy baby.

Operations

You can include in medical expenses amounts you pay for legal operations that are not for unnecessary cosmetic surgery. See **Cosmetic Surgery** under **What Expenses Are Not Deductible**, later.

Optometrist

See **Eyeglasses**, earlier.

Organ Donors

See **Transplants**, later.

Osteopath

You can include in medical expenses amounts you pay to an osteopath for medical care.

Oxygen

You can include in medical expenses amounts you pay for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.

Prosthesis

See **Artificial Limb**, earlier.

Psychiatric Care

You can include in medical expenses amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill Spouse or Child at a specially equipped medical center where the Spouse or Child receives medical care. See **Psychoanalysis**, next, and **Transportation**, later.

Psychoanalysis

You can include in medical expenses payments for psychoanalysis. However, you cannot include payments for psychoanalysis that you must get as a part of your training to be a psychoanalyst.

Psychologist

You can include in medical expenses amounts you pay to a psychologist for medical care.

Schools and Education, Special

You can include in medical expenses payments to a special school for a mentally impaired or physically disabled person if the main reason for using the school is its resources for relieving the disability. You can include, for example, the cost of:

- Teaching Braille to a visually impaired Child.
- Teaching lip reading to a hearing impaired Child.
- Giving remedial language training to correct a condition caused by a birth defect.

The cost of meals, lodging, and ordinary education supplied by a special school can be included in medical expenses only if the main reason for the child's being there is the resources the school has for relieving the mental or physical disability.

You cannot include in medical expenses the cost of sending a problem Child to a special school for benefits the Child may get from the course of study and the disciplinary methods.

Sterilization

You can include in medical expenses the cost of a legal sterilization (a legally performed operation to make a person unable to have children).

Stop-Smoking Programs

You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Surgery

See **Operations**, earlier.

Telephone

You can include in medical expenses the cost and repair of special telephone equipment that lets a hearing-impaired person communicate over a regular telephone.

Television

You can include in medical expenses the cost of equipment that displays the audio part of television programs as subtitles for hearing-impaired persons. This may be the cost of an adapter that attaches to a regular set. It also may be the portion of the cost of a specially equipped television that exceeds the cost of the same model regular television set.

Therapy

You can include in medical expenses amounts you pay for therapy you receive as medical treatment.

"Patterning" exercises. You can include in medical expenses amounts you pay to an individual for giving "patterning" exercises to a mentally retarded Child. These exercises consist mainly of coordinated physical manipulation of the Child's arms and legs to imitate crawling and other normal movements.

Transplants

You can include in medical expenses payments you make for surgical, hospital, laboratory, and transportation expenses for a donor or a possible donor of a kidney or other organ. You cannot include expenses if you did not pay for them.

A donor or possible donor can include surgical, hospital, laboratory, and transportation expenses in medical expenses only if he or she pays for them.

Transportation

You can include in medical expenses amounts paid for transportation primarily for, and essential to, medical care.

You can include:

- Bus, taxi, train, or plane fares, or ambulance service.
- Transportation expenses of a parent who must go with a Child who needs medical care.
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone.
- Transportation expenses for regular visits to see a mentally ill Spouse or Child, if these visits are recommended as a part of treatment.

You cannot include:

- Transportation expenses to and from work, even if your condition requires an unusual means of transportation.

- Transportation expenses if, for nonmedical reasons only, you choose to travel to another city, such as a resort area, for an operation or other medical care prescribed by your doctor.

Car expenses. You can include out-of-pocket expenses for your car, such as gas and oil, when you use your car for medical reasons. You cannot include depreciation, insurance, general repair, or maintenance expenses.

If you do not want to use your actual expenses, you can use a standard rate of **10 cents a mile** for use of your car for medical reasons.

You can also include the cost of parking fees and tolls. You can add these fees and tolls to your medical expenses whether you use actual expenses or use the standard mileage rate.

Example. Bill Jones drove 2,800 miles for medical reasons during the year. He spent $200 for gas, $5 for oil, and $50 for tolls and parking. He wants to figure the amount he can include in medical expenses both ways to see which gives him the greater deduction. He figures the actual expenses first. He adds the $200 for gas, the $5 for oil, and the $50 for tolls and parking for a total of $255.

He then figures the standard mileage amount. He multiplies the 2,800 miles by 10 cents a mile for a total of $280. He then adds the $50 tolls and parking for a total of $330.

Bill includes the $330 of car expenses with his other medical expenses for the year because the $330 is more than the $255 he figured using actual expenses.

Trips

You can include in medical expenses amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You may be able to include up to $50 per night for lodging. See **Lodging**, earlier.

You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or general improvement of health, even if you make the trip on the advice of a doctor.

Tuition

You can include in medical expenses charges for medical care included in the tuition of a college or private school, if the charges are separately stated in the bill or given to you by the school. See **Learning Disability**, earlier, and **Schools and Education, Special**, earlier.

Vasectomy

You can include in medical expenses the amount you pay for a vasectomy.

Weight-Loss Program

You can include in medical expenses the cost of a weight-loss program undertaken at a physician's direction to treat an existing disease (such as heart disease). But you cannot include the cost of a weight-loss program if the purpose of the weight control is to maintain your general good health.

Wheelchair

You can include in medical expenses amounts you pay for an autoette or a wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and keeping up the autoette or wheelchair is also a medical expense.

X-ray Fees

You can include in medical expenses amounts you pay for X-rays that you get for medical reasons.

What Expenses Are Not Deductible?

Following is a list of some items that you **cannot** include in figuring your medical expense deduction. The items are listed in alphabetical order.

Baby Sitting, Child Care, and Nursing Services for a Normal, Healthy Baby

You cannot include in medical expenses amounts you pay for the care of your Children even if the expenses enable you to get medical or dental treatment. Also, any expense allowed as a childcare credit cannot be treated as an expense paid for medical care. See also **Healthy baby** under **Nursing Services**, earlier.

Controlled Substances

You cannot include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.). Such substances may be legalized by state law. However, they are in violation of federal law and cannot be included in medical expenses.

Cosmetic Surgery

Generally, you cannot include in medical expenses the amount you pay for unnecessary cosmetic surgery. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. Procedures such as face-lifts, hair transplants, hair removal (electrolysis), and liposuction generally are not deductible.

You can include in medical expenses the amount you pay for cosmetic surgery if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Dancing Lessons

You cannot include the cost of dancing lessons, swimming lessons, etc., even if a doctor recommends them, if they are only for the improvement of general health.

Diaper Service

You cannot include in medical expenses the amount you pay for diapers or diaper services, unless they are needed to relieve the effects of a particular disease.

Electrolysis or Hair Removal

See **Cosmetic Surgery**, earlier.

Funeral Expenses

You cannot include in medical expenses amounts you pay for funerals.

Hair Transplant

See **Cosmetic Surgery**, earlier.

Health Club Dues

You cannot include in medical expenses health club dues, YMCA dues, or amounts paid for steam baths for your general health or to relieve physical or mental discomfort not related to a particular medical condition. You cannot include in medical expenses the cost of membership in any club organized for business, pleasure, recreation, or other social purpose.

Household Help

You cannot include in medical expenses the cost of household help, even if a doctor recommends such help. This is a personal expense that is not deductible. However, you may be able to include certain expenses paid to a person providing nursing-type services. Also, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses.

Illegal Operations and Treatments

You cannot include in medical expenses amounts you pay for illegal operations, treatments, or controlled substances whether rendered or prescribed by licensed or unlicensed practitioners.

Insurance Premiums for Certain Types of Policies

This Plan does not cover insurance premiums paid by you for any type of insurance policy.

Maternity Clothes

You cannot include in medical expenses amounts you pay for maternity clothes.

Nonprescription Drugs and Medicines

Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Personal Use Items

You cannot include in medical expenses an item ordinarily used for personal, living, or family purposes unless it is used primarily to prevent or alleviate a physical or mental defect or illness. For example, the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease can be included with medical expenses. Where an item purchased in a special form primarily to alleviate a physical defect is one that in normal form is ordinarily used for personal, living, or family purposes, the excess of the cost of the special form over the cost of the normal form is a medical expense (see **Braille Books and Magazines** under ***What Medical Expenses Are Deductible***, earlier).

Swimming Lessons

See **Dancing Lessons**, earlier.

Weight-Loss Program

You cannot include the cost of a weight-loss program in medical expenses if the purpose of the weight control is to maintain your general good health. But you can include the cost of a weight-loss program undertaken at a physician's direction to treat an existing disease (such as heart disease).

Can I "opt out" of Miscellaneous and Prescription Medicine Benefits?

Yes. Under the Affordable Care Act, accounts like the Miscellaneous and Prescription Medicine Benefits Accounts are required to allow you to opt out permanently at least annually and when employment ends. This is because some plans allow people to continue to receive reimbursement after eligibility for basic benefits ends, and that coverage will disqualify the person from tax credits and other advantages of buying individual Marketplace coverage. You can permanently opt out of Miscellaneous and Prescription Medicine Benefits at any time by filing a written election with the Plan Administrator. However, you should only need Marketplace coverage if and when your coverage under the Plan ends, and because Miscellaneous and Prescription Medicine Benefits will cease whenever your eligibility for coverage by the Plan ends, you should not need to opt out of or waive these benefits to become eligible for the advantages of Marketplace coverage.

SECTION 11

INDIVIDUAL HEALTH REIMBURSEMENT ACCOUNT

Who is eligible for an Individual Health Reimbursement Account?

Currently, only Building Trades and Gas Distribution Members are eligible. If you are not working in the Building Trades or Michigan or Ohio Gas Distribution classifications, this section does not apply to you.

What is the Individual Health Reimbursement Account?

Each month in which you are eligible for Basic Benefits, an Employer contribution for each hour you work will be credited to an Individual Health Reimbursement Account under the separate Individual HRA Plan and Trust for your benefit. You can use this to:

- Pay your self-pay contributions to maintain coverage under this Plan if your hours are reduced below the 100-hour monthly minimum for any reason (layoff, unemployment, reduced hours, disability, or retirement); or

- Pay for other medical coverage for you, your Spouse or Children after retirement (for example, Medicare premiums); or

- Pay expenses otherwise eligible under Miscellaneous Benefits for you, your Spouse or Children once your Miscellaneous Benefits for the year have been used up.

This Account is intended primarily as a way to help pay for part of your medical expenses in retirement. **If possible, you should use it before retirement only as a last resort.**

How will the amount in my Individual Health Reimbursement Account be determined?

The Administrative Manager maintains Account records for each eligible Participant. Contributions are credited to this Account each month and amounts paid from the Account are subtracted each month. The monthly status report that you currently receive will show any additional contributions to the Account for the month and will reflect the total unused amount in the Account as of the end of the month. The monthly status report will not show details of each expense paid for the month. You will receive an annual status report that will show complete detail for the entire year.

Will the Individual Health Reimbursement Account be credited with investment income, losses and administrative expenses?

Yes. Whatever part of the Individual Health Reimbursement Account is not used will be carried forward and will accumulate earnings or have losses subtracted from it. Administrative expenses will also be charged against all Accounts. The Trustees invest these funds separately from the rest of the Health and Welfare Plan assets. Earnings and losses are only credited to or subtracted from the Account at the end of the Plan Year, and are shared based on the amount in the Account on the last day of the Plan Year. So any amounts withdrawn from the Account during the year will not share in the earnings. Expenses may be subtracted on a per account basis or as a percentage of Account assets, depending on the type of expense.

Unused amounts and earnings carry forward from year to year and grow tax-free to help cover medical costs after retirement. **Because of the tax-free growth of this Account, it is always better to pay your self-payments and other expenses directly so you can accumulate the maximum amount to help pay for medical expenses in retirement.**

Are amounts paid from the Account subject to income tax?

No. The Account funds are held in the tax-exempt Health Fund, and amounts used to pay self-payments, premiums, or medical expenses are not included in your taxable income.

Can I use the Individual HRA to pay co-pay amounts (and co-insurance amounts under Standard Coverage)?

Yes. Co-payments and co-insurance on Basic Benefits that are not eligible under the Miscellaneous Benefit will be eligible under the Individual HRA Benefit and any expenses incurred at a physician's office, hospital or with another health care provider will be assumed to be deductibles, co-payments (and co-insurance under Standard Coverage) and will be deducted from any remaining balance in your Individual HRA account.

Because the Miscellaneous Benefit will pay Delta Dental co-pays as an exception to the general rule, the Individual HRA may be used to pay co-pays under the Delta Dental benefits under the Health and Welfare Plan once the Miscellaneous Benefits have been exhausted for the claim year.

In what situations may my Individual HRA account be depleted when I use the Benefit Advisor Card even though I have Miscellaneous Benefits left?

When you use your Benefit Advisor Card to pay for services rendered by a Nonparticipating Provider, since the expense is coded as a medical expense, and is not a prescription medicine, dental or vision expense, your Individual HRA balance will be used before your Miscellaneous Benefits. If you wish to use your Miscellaneous Benefits instead, you may submit amounts charged for services provided by Nonparticipating Providers to the Fund Office for manual processing. You should only submit Nonparticipating Provider balance billings to the Fund Office for manual processing; all deductibles and co-pay amounts (and co-insurance under Standard Coverage) may only be reimbursed by using the Benefit Advisor Card.

How do I use the Individual HRA to pay my self-pay amounts?

Contact the Administrative Manager to obtain an Individual HRA Reimbursement Request Form. Fill out the form and send it to the Administrative Manager, asking to have the self-pay amounts taken from the Individual HRA. This will <u>not</u> happen automatically.

The Administrative Manager will assume that you want to save the Individual HRA for use later in retirement and will expect you to make your self-payment directly unless you elect in writing to use the Individual HRA for self-payments.

How do I use the Individual HRA to pay for eligible expenses after my Miscellaneous Benefits are used up?

Once your Miscellaneous Benefits are used up, eligible expenses will be automatically deducted from the remaining balance in your Individual HRA. This will happen when you use your Benefit Advisor Card (with your BCBSM Card for prescriptions). For providers that do not accept VISA, after you have paid an expense that is eligible for reimbursement, contact the Administrative Manager to obtain an Individual HRA Reimbursement Request Form. Fill out the form and send it to the Administrative Manager. You will be asked to submit proof supporting the type of expense incurred and proof of payment. After processing the request, the Administrative Manager will send you a reimbursement check.

What happens when the Individual HRA runs out of money?

If you are still actively working in an eligible classification, new contributions will be added as you work more hours. If you are retired, there will be no more benefits available once the Individual HRA is used up.

What if there are funds left in my Individual HRA when I die?

Whatever is left in your Individual HRA can continue to be used by your Spouse and Children for self-payments or eligible expenses. If there is nobody eligible to continue to use these benefits, then at the end of the year in which nobody is eligible, the remaining balance will be added to Individual HRA income for the year and allocated together with all other income to all accounts eligible for income allocations.

What happens to Individual HRA balances when transfer to another Health Care Fund is requested under reciprocity?

If you request a transfer of your Individual HRA contributions under a reciprocity agreement with another Fund, your Individual HRA will be transferred to the other Fund in accordance with the reciprocity agreement. Any Individual HRA funds not accepted by the reciprocal Fund will be forfeited and allocated to other Individual HRAs at the end of the Plan Year as additional earnings.

What happens when Individual HRA balances become too small to administer?

To keep the costs of administering the Fund reasonable, the Individual HRA of a Participant who is not Actively at Work will be cancelled at the end of the Plan Year if the Individual HRA has become too small to provide any significant benefit. An Individual HRA is considered too small to provide any significant benefit if its balance at the end of the Plan Year, before allocating income for the year, is less than $75.00. Any funds from Individual HRAs cancelled under this rule will be forfeited before income is allocated for the Plan Year. The forfeited amount will be allocated to other Individual HRAs at the end of the Plan Year as additional earnings.

What happens to my contributions when I am not eligible for Basic Benefits?

When you are not covered under Basic Benefits, new Employer contributions cannot be credited to your account. Instead, they will be segregated in a separate bookkeeping account ("suspended contribution credits"). If you become eligible or re-eligible for Basic Benefits coverage (by earning 520 hours of credit in a 12-month period) before those credits are reallocated to other Participants, those credits will be credited to your Individual HRA as of the first day of your first month of new Basic Benefits coverage. If you do not regain Basic Benefits eligibility, your suspended contribution credits will be treated as earnings and will be reallocated to other Participants' Individual HRAs as of each May 31, but only if you are not eligible at that time and your ineligibility has lasted 12 consecutive months or more. (Note that when you lose eligibility, you can continue to submit claims to use your remaining balance; the suspension only applies to new contributions.)

Can I "opt out" of Individual HRA coverage?

Yes. Under the Affordable Care Act, accounts like the Individual HRA are required to allow you to opt out permanently at least annually and when employment ends. This is because when you lose eligibility, you can continue to submit claims to use your remaining balance. The right to keep submitting for reimbursement may disqualify you from tax credits and other advantages of buying individual Marketplace coverage. You can permanently opt out of the Individual HRA at any time by filing a written election with the Plan Administrator.

SECTION 12

LIFE INSURANCE DEATH BENEFIT

Does my family receive a Life Insurance Death Benefit if I die as a Participant?

If at the time of death you are not retired and are either (a) an Actively at Work Participant, or (b) covered under the Plan by making self-payments, your named Beneficiary is entitled to a Life Insurance Death Benefit. For this purpose, a member who is making self-payments while Totally and Permanently Disabled will not be treated as "retired" until attaining age 60, even if drawing Disability Retirement Benefits under the UA Local 190 Pension Plan. At the time of death, the Administrative Manager's Office should be contacted promptly so that necessary forms and instructions for filing a Life Insurance Death Benefit claim may be furnished to the named Beneficiary. Life Insurance Death Benefits are applicable to those persons who meet the eligibility rules on the date of death. Written notice of the death of an eligible Participant must be given to the Administrative Manager's Office within 90 days of the date of death of the Participant; otherwise no Life Insurance Death Benefit will be payable. Effective for deaths occurring on or after August 1, 2012, the Life Insurance Death Benefit is $15,000.

Effective December 1, 2015, you may apply and pay for optional supplemental group term life insurance coverage through MetLife for yourself, your Spouse and your Children (with the requirement that your Children be between 15 days and 26 years old and supported by you) in the amounts described below:

For You: $25,000 to $100,000 in $25,000 increments ($25,000 minimum and $100,000 maximum)

For your Spouse: $5,000 increments to a maximum of $20,000, not to exceed 50% of your supplemental life insurance coverage benefit amount

For your Children:	For a Child 15 days to 6 months old:	$ 1,000
	For a Child more than 6 months old, the following options:	$ 1,000
		$ 2,000
		$ 4,000
		$ 5,000
		$10,000

Effective December 1, 2015, you may apply and pay for optional, supplemental individual whole life insurance coverage through Texas Life Insurance Company for yourself, your Spouse, your Children and your grandchildren in the amounts described below*:

For You (if you are aged 17-70):

Minimum, initial face amount: ages 17-49 $10,000; ages 50-70 $5,000

Guaranteed Issue (Tier 1) maximum initial face amount: $75,000 ages 17-39; $50,000 ages 40-49; $25,000 ages 50-59; $15,000 ages 60-70

Express Issue (Tier 2) maximum initial face amount: $150,000 ages 17-39; $100,000 ages 40-49; $50,000 ages 50-59; $30,000 ages 60-70

Simplified Issue (Tier 3) maximum initial face amount: $250,000 ages 17-70

For your Spouse (age 17-70):

Minimum, initial face amount: ages 17-49 $10,000; ages 50-70 $5,000

Guaranteed Issue (Tier 1) maximum initial face amount: N/A

Express Issue (Tier 2) maximum initial face amount: $50,000 ages 17-49; $25,000 ages 50-59; $10,000 ages 60-70

Simplified Issue (Tier 3) maximum initial face amount: $75,000 ages 17-49; $50,000 ages 50-59; $25,000 ages 60-70

For your Children (ages 15 days-26 years) and
For your grandchildren (ages 15 days-18 years):

Minimum only, initial face amount: $10,000

*Spouses, Children and grandchildren are eligible regardless of whether the corresponding employee applies for coverage. Policies for Spouses, Children and grandchildren are not available in all states.

The optional, individual whole life insurance coverage through Texas Life Insurance Company is individually underwritten and rates are guaranteed.

Initial face amount: Prior to age 65, or if 20 or fewer years have elapsed from the date coverage was purchased if it was purchased after age 45, the death benefit is equal to the initial face amount. Upon the insured's death, the insured's beneficiary will receive the death benefit if all policy requirements are met.

Neither of these optional, supplemental life insurance options are available to Retirees.

May I convert my Life Insurance Death Benefit if I retire or terminate my covered employment?

If you retire or terminate your work under the Local 190 jurisdiction, cease to be in an eligible class, the group policy ends (provided you have been insured for life insurance for at least five continuous years) or if the group policy is amended to end all life insurance for an eligible class of which you are a member (provided you have been insured for at least five continuous years),you may convert the standard Fund-provided life insurance coverage to an individual policy of life insurance within 31 days without medical examination. **Your insurance does not continue unless you convert it**. You should ask for a conversion application form as soon as possible. If you are given written notice of the option to convert within 15 days before or after the date your life insurance ends, the application period begins on the date that such life insurance ends and expires 31 days after such date. If you are given written notice of the option to convert more than 15 days after the date your life insurance ends, the application period begins on the date such life insurance ends and expires 15 days from the date of such notice. In no event will the application period exceed 91 days from the date your life insurance ends. Conversion coverage is also contingent on any other requirements of the current insurer.

The amount of the conversion policy will not exceed the amount provided under the group Plan. If your life insurance ends due to the end of the group policy or amendment of the group policy ends all life insurance for an eligible class of which you are a member, the maximum amount of insurance that you may elect for the new policy is the lesser of: 1) the amount of your life insurance that ends under the group policy less the amount of life insurance for which you become eligible under any group policy within 31 days after the date insurance ends under the group policy; or 2) $10,000. If your life insurance ends due to the Plan sponsor's restructuring, the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance that ends under the group policy less the amount of life insurance for which you become eligible under any other group policy within 31 days after the date insurance ends under the group policy. If your life insurance ends for any other reason, the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance which ends under the group policy. You may choose any type of individual policy except term insurance then being written by the carrier the Plan then has. The premium cost to you will be based upon the insurer's rate then in use, the form and amount of insurance for which you apply, your class of risk and your age at the time of conversion. Contact the Administrative Manager's Office well in advance if you wish to have this coverage.

For any supplemental group term life insurance coverage you may have purchased, if you retire, the group policy ends, you cease being eligible under the group policy, you fail to pay the premium or fail to make required self-payments under the Plan for any month in which you work less than 100 hours, (provided you have been insured for such coverage for at least five continuous years), you may convert a portion of your coverage to an individual policy of life insurance if you complete and provide MetLife a conversion application within 31 days after your life insurance ends (if you are given written notice of the conversion option within 15 days before or after the date your life insurance coverage ends) or within 15 days after the date you are given written notice of the option to convert that is more than 15 days after the date your life insurance ends (but in no event may the application be provided more than 91 days from the date your life insurance ends).

For dependent (for your Spouse and dependent Children) supplemental group life insurance coverage purchased at your own expense, if you retire, the group policy ends (provided you have been insured for life insurance for the dependent for at least 5 continuous years) or the group policy is amended to cease life insurance for dependents for an eligible class of which you are a member (provided you have been insured for life insurance for the dependent for at least 5 continuous years) you will have the option to convert life insurance for the dependent.

The dependent will have the option to convert when the life insurance for the dependent ends because the dependent ceases to be eligible as a dependent under the group policy or you die.

For conversion of dependent life insurance under either of the above two paragraphs, if written notice of the option to convert is given within 15 days before or after the date life insurance for the dependent ends, the application period begins on the date the life insurance ends and expires 31 days later. If written notice of the conversion option is provided more than 15 days after the date life insurance for the dependent ends, the application period beings on the date the life insurance ends and expires 15 days following date of the notice, and in no event will the application period exceed 91 days from the date the dependent life insurance ends.

Can I port my Life Insurance Death Benefit if I retire or terminate my covered employment?

For the optional supplemental group term Life Insurance Death Benefit coverage, there is an option to "port" a portion of your coverage upon your retirement, termination of employment, ceasing to be a member of a class that is eligible for the insurance, or if the portability option for this coverage ends, unless the insurance is replaced by similar insurance under another group insurance policy. "Porting" coverage means continuing group coverage under another group policy at group rates. MetLife maintains a separate pooled group for this purpose and rates may be lower under this option than under the conversation option.

The optional supplemental group Life Insurance Death Benefit coverage for you, your Spouse and your dependent Children is portability-eligible in maximum amounts that may be less than the original coverage. Porting may only be exercised via a written request within the following time limits: if written notice of the option to port is given within 15 days before or after the date insurance ends, the request period begins on the date the insurance ends and expires 31 days after that date. If written notice of the option to port is given more than 15 days but within 91 days of the date insurance ends, the request period begins on the date the insurance ends and expires 45 days after the date of the notice. If written notice of the option to port is not given within 91 days of the date insurance ends, the request period begins on the date the insurance ends and expires at the end of the 91 day period.

SECTION 13

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Is an Accidental Death and Dismemberment Benefit paid if I die accidentally or if I am dismembered?

Yes, this benefit (the basic Accidental Death and Dismemberment benefit covered by the Plan) is paid in addition to any other benefits that may be payable by the Plan and is not subject to Coordination of Benefits. You must be eligible by Employer contributions or self-payments and be an Actively at Work Participant, a Participant who is not Actively at Work who is covered under the Plan by making self-payments, or a Participant who is a Totally and Permanently Disabled Participant who is covered under the Plan by making self-payments at the time of the accident. Premiums can be waived for accidental death & dismemberment coverage if you are receiving a disability pension under the UA Local 190 Pension Plan, if you apply for disability premium waiver and it is approved by the current insurance carrier. If you retire, the standard Accidental Death and Dismemberment Benefit that is covered by the Fund is <u>not</u> available unless you convert your Life Insurance Death Benefit as described in Section 12.

The Accidental Death Benefit paid to your named Beneficiary in the event of your death as an active Member is $15,000 effective August 1, 2012. This is in addition to the Life Insurance Death Benefit, which for active Members, is also $15,000 effective August 1, 2012. This is an insurance benefit the Fund provides through purchasing a group policy that covers your life.

How much am I paid if I suffer dismemberment but don't die?

In the event you sustain any of the following losses through external, violent or accidental means, on or off the job, the indicated percentage of the Accidental Death and Dismemberment Benefit will be paid in addition to any other benefits payable under the Plan:

Loss of a combination of hand, foot, or sight of one eye or other combination as defined in the current insurance policy	100%
Loss of arm at or above the elbow or loss of leg at or above the knee	75%
Loss of hand at or above the wrist but below elbow Or loss of foot at or above the ankle but below the knee	50%

What are the rules for payment of the basic Accidental Death and Dismemberment Benefit?

The loss must occur within 12 months from the date of the accidental injury and be a direct result of the accidental injury, independent of other causes.

The loss of a limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the permanent and uncorrectable loss of sight in the eye; visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

In no event will more than the full amount of the Accidental Death and Dismemberment Benefit be payable.

Are there situations where the Accidental Death and Dismemberment Benefit will not be paid?

Yes. Payment of the Accidental Death and Dismemberment Benefit will not be made for death or any loss resulting from or caused directly, wholly or partly by:

- Physical or mental infirmity, or the diagnosis or treatment of such illness or infirmity;;

- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Participation in the committing or attempted committing of a felony;
- Most service in the armed forces of any country or international authority;
- Any incident related to travel in an aircraft other than as a passenger, and incidents related to travel in an aircraft for parachuting, jumping from an aircraft or experimental air travel or space travel;
- The voluntary intake or use by any means or any drug, medication or sedative, unless it is taken or used as prescribed by a Physician; or an "over the counter" drug, medication or sedative taken as directed;
- The voluntary intake or use by any means of alcohol in combination with any drug, medication or sedative;
- The voluntary intake or use by any means of poison, gas, or fumes;
- War, whether declared or undeclared, or an act of war, insurrection, rebellion or active participant in a riot; or
- Any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Do I have any other options for Accidental Death and Dismemberment benefits?

Yes. Effective December 1, 2015, if you obtain the optional supplemental group life insurance coverage, you will be enrolled in the optional supplemental group accidental death and dismemberment coverage. You must be eligible by Employer contributions or self-payments and be an Actively at Work Participant, a Participant who is not Actively at Work who is covered under the Plan by making self-payments, or a Participant who is a Totally and Permanently Disabled Participant who is covered under the Plan by making self-payments at the time of the accident.

The Accidental Death Benefit paid to your named Beneficiary in the event of your death is an amount equal to your supplemental group life insurance benefits.

How much am I paid if I suffer dismemberment but don't die?

In the event you sustain any of the following losses through external, violent or accidental means, on or off the job, the indicated percentage of the supplemental Accidental Death Benefit will be paid in addition to any other benefits payable under the Plan and under the optional, supplemental life insurance coverage options:

Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%
Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%
Loss of sight in one eye	50%

(Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.)

Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of the same hand	25%

(Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.)

Loss of speech and loss of hearing	100%
Loss of speech or loss of hearing	50%

(Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury. Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.)

Paralysis of both arms and both legs	100%
Paralysis of both legs	50%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%

(Paralysis means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.)

Brain Damage	100%

(Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all substantial and material functions and activities of normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persist for 12 consecutive months after the date of the accidental injury.)

Coma	1% monthly beginning on the 7th Day of the Coma for the duration Of the Coma to a maximum of 60 Months

(Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.)

Are there situations where the optional supplemental Accidental Death and Dismemberment Benefit will not be paid?

Yes. Payment of the optional supplemental group Accidental Death and Dismemberment Benefit will not be made for death or any loss resulting from or caused directly, wholly or partly by:

- Physical or mental infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;

- Intentionally self-inflicted injury;
- Participation in the committing or attempted committing of a felony;
- Most service in the armed forces of any country or international authority;
- Any incident related to travel in an aircraft other than as a passenger, and incidents related to travel in an aircraft for parachuting, jumping from an aircraft or experimental air travel or space travel;
- The voluntary intake or use by any means of any drug, medication or sedative, unless it is taken or used as prescribed by a Physician, or an "over the counter" drug, medication or sedative taken as directed;
- The voluntary intake or use by any means of alcohol in combination with any drug, medication or sedative;
- The voluntary intake or use by any means of poison, gas, or fumes;
- War, whether declared or undeclared, or an act of war, insurrection, rebellion or active participation in a riot; or
- Any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

May I convert or port my Accidental Death and Dismemberment Benefit?

There is no conversion or port option for the basic Accidental Death and Dismemberment Benefit.

There is an option to port a portion of the optional supplemental accidental death and dismemberment benefit (see the discussion of "porting" above). There is no option to convert any portion of the optional supplemental accidental death and dismemberment benefit.

SECTION 14

LOSS OF TIME BENEFITS

Can I get paid anything if I can't work because of an injury or sickness incurred off the job?

Yes. If, while covered, you become disabled to the extent you are unable to work because of a non-occupational Accidental Injury or sickness, then you will be entitled to receive a weekly benefit called Loss of Time Benefits, currently $300 a week. If you are injured on the job, you are covered by Workers' Compensation, and Loss of Time Benefits do not apply.

You must be eligible for coverage (either under the 100-hour rule or by having your self-pay status current) at the time you become disabled and at the time you file your claim. Claims must be filed no later than 60 days after you become disabled. See **Claim Procedure for Fund Coverages of Miscellaneous Benefits, Prescription Medicine Benefits, and Loss of Time Benefits** in **Section 21, Filing Claims And Appeals**.

For what period are benefits paid?

Benefits will begin as of the first day of disability due to an accident or as of the eighth day of disability due to sickness and will continue for any one period of disability up to 26 weeks. Benefits are payable on the basis of the normal five-day workweek. No benefits are payable during any period you are receiving pension benefits.

Successive disability periods separated by less than two weeks of continuous active employment are considered as one continuous period of disability unless they arise from different and unrelated causes.

You do not have to be confined to your home to collect benefits, but you must be under the care of a physician. No disability will be considered as beginning more than three days prior to the first visit of or to a physician.

What if my injury is incurred on the job?

This Loss of Time Benefit does not apply if you suffer an occupational injury. In that case the Plan does not cover you, and your costs are handled under a Workers' Compensation procedure.

However, you may also receive a benefit if you are dismembered, even on the job. See **Section 13, Accidental Death and Dismemberment Benefit**.

NOTE: This benefit is not available to retirees.

SECTION 15

PRE-EXISTING CONDITIONS

Exclusion Period

What are some of the special rules regarding my coverage if I had treatment for an illness before I had Plan coverage?

A pre-existing condition is any physical or mental condition, except pregnancy, for which medical advice, diagnosis, care or treatment was recommended or received from a licensed care giver within the six-month period ending on the date of your hire from which your 520 hours of covered employment was calculated.

Before January 1, 2014, you would have to wait 90 days in order to have a pre-existing condition covered. Effective January 1, 2014, this rule no longer applies.

SECTION 16

MEDICAL CARE OUTSIDE OF THE UNITED STATES

What if I receive medical services outside of the United States?

The Basic Benefits provided by the Blue Cross Blue Shield program cover services outside the 50 states, but only through the claim procedure described in Section 21, Filing Claims and Appeals. See that section for specifics of how to file a claim. In these cases, Blue Cross Blue Shield will pay reimbursement to you in accordance with its own schedules. You may not be reimbursed for your entire bill. Reimbursement will be based on what is reasonable and customary in the area where services are rendered.

Except for emergency treatment, you must have prior approval from the Trustees for elective care outside the U.S. The Fund will not pay transportation or accommodation expenses.

SECTION 17

MEDICARE, SUPPLEMENTAL COVERAGE, AND END STAGE RENAL DISEASE (ESRD)

Are retirees covered by the Plan?

Effective June 1, 2015, Medicare-Eligible Retirees (retirees age 65 or older) are covered by the UA Local 190 Medicare Retiree Health and Welfare Plan, a separate plan which is identical to the UA Local 190 Health and Welfare Plan covering active employees with the exception that prescription medicine expenses for those Members will not count toward the TrOOP annual out-of-pocket limit. All other retirees are covered by the UA Local 190 Health and Welfare Plan.

If you return to work following retirement and you are a Medicare-Eligible Retiree, your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan terminates and you become covered under the UA Local 190 Health and Welfare Plan immediately upon your return to work, without having to complete a new period of 520 hours of covered employment. Once you stop working, your coverage under the UA Local 190 Health and Welfare Plan terminates and your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan resumes.

Medicare Coverage

What is Medicare?

Medicare is a federal health care program designed to provide health care benefits to persons aged 65 and older 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 End Stage Renal Disease (ESRD). However, you are eligible to 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, or you will be required to pay extra premiums for your Medicare insurance.

Medicare coverage has three parts: hospital insurance Part A, medical insurance Part B and prescription coverage Part D. Part A helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Part B medical insurance helps pay for physician's services and other medical services and items. Part D helps pay for the cost of prescription medications.

The Part A hospital insurance portion is provided by the government at no cost to you. However, you must pay monthly for the Part B medical portion and the Part D prescription portion. These premiums are adjusted annually. You will be notified of the change in premium for the part B by the Social Security Administration before each new year.

Employed Persons Aged 65 or Older

What if I am still employed when my Spouse or I reach age 65?

When you reach 65 and become eligible for Medicare, but are still working, the Fund continues as your primary health care plan, and Medicare becomes your secondary health care plan.

Important: Even though you continue to be covered by your group plan as your primary plan, you should still apply for Medicare benefits, especially Part A and Part D.

- Part A of Medicare, the hospital insurance, is offered without cost to you. It may provide additional benefits to your group coverage.

- Part B of Medicare, the medical insurance, is also available. However, because you pay for this coverage, you can delay enrollment in Part B without penalty **as long as you are covered by our Plan**.

- Part D of Medicare, the prescription medication insurance, is also available. The Prescription Medicine Benefit coverage under the Plan is not expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because it is not as beneficial as Medicare Part D, it is considered "non-creditable coverage." This means that it is to your benefit to enroll in a Medicare Part D prescription drug plan as soon as you are eligible. If you do not join a Medicare prescription drug plan as soon as you are eligible, you will have to pay more for the Medicare Part D prescription coverage when you lose coverage under the Plan or decide to leave the Plan. You will pay that higher premium as long as you have Medicare prescription drug coverage.

If you delay enrolling for Medicare Part B coverage when you reach age 65 because you are still covered by our Plan, 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.

In most cases, (other than in the case of prescription medication coverage) the Fund's benefits are more generous for an employed person than those provided under Medicare. Where they are not, you retain the right to file your claims with Medicare for whatever additional coverage is available.

Any time after the age of 65 that you cease to meet the definition of an Actively at Work Participant, Medicare becomes your primary payer, and you are then entitled to apply for Supplemental Coverage, described below. **You should immediately apply for Medicare Part B coverage when you cease being an Actively at Work Participant** – failure to do so will cause you to pay a substantial penalty on your lifetime Medicare Part B premiums once you do enroll.

Blue Cross Blue Shield Supplemental Coverage For Participants On Medicare

What if I am retired when I reach age 65?

It is assumed by the Plan that any retired person who is entitled to Medicare has all Medicare benefits, including Part A and Part B, and any replacements thereof. Therefore, this Plan will pay benefits for retired Participants and their Spouses and Children only after coverage paid by Medicare, or after coverage for which Medicare should have paid, regardless of whether you have the coverage or not. Be sure that you obtain both Medicare Part A and Part B coverage.

If you wish more coverage than that offered you by Medicare, you may get Supplemental Coverage, which you may acquire on a self-pay basis. Supplemental Coverage works with Medicare to extend your health care benefits. The coverage works as follows:

As a Medicare-Eligible Retiree, your prescription medicine expenses will not count toward the TrOOP annual out-of-pocket limit.

Supplement to Medicare Program

If you are retired when you reach age 65, you are eligible for the Blue Cross Blue Shield Supplemental Coverage if:

- You are a Participant in the Plan at the time you reach age 65, and

- You are eligible to receive monthly benefits from the UA Local 190 Pension Fund.

If you are eligible, other rules apply as follows:

- You must have both **Medicare Part A and Part B** coverage if you wish to have all available coverage. The Fund pays supplemental benefits as if you had the Medicare Part A and Part B coverage. A copy of your Medicare card and/or your Spouse's Medicare card must be submitted.

- You must be a Member in good standing with Local 190. Status will be checked when you are added to the program and will be checked each month thereafter.

- Coverage is available only when Employer contributions have terminated.

- You and/or your Spouse are eligible to be added on the first day of the month you and/or your Spouse become eligible for both Medicare Part A and Part B coverage.

- Your Spouse is eligible to be added to this program only if you meet the above requirements. In addition, as above described to get full coverage, you must be maintaining coverage for yourself under one of the retired Participant Self-Payment Programs. Your Spouse must have both Medicare Part A and Part B coverage. Your Spouse must elect to be covered under the Plan when you retire; otherwise your Spouse becomes ineligible.

- You must elect this coverage when it first becomes available to you. You cannot retire, drop our Plan, and later try to add it back without first becoming an Actively at Work Participant and working the required amount of hours.

- As a Medicare-Eligible Retiree, your prescription medicine expenses will not count toward the TrOOP annual out-of-pocket limit.

Schedule of Benefits

What coverage is provided?

The Supplement to the Medicare Program is designed to make sure that individuals covered by Medicare will have the same amount covered by the Plan as would be the case for an Active Participant who was not covered by Medicare. In other words, in most cases the Plan pays the portion that is not paid by Medicare and would have been paid by the Plan if you were Active.

If your provider has agreed to accept the Medicare approved amount as full payment for a service, this means that a claim for that service is an Assigned Claim. If your provider has not agreed to accept the Medicare approved amount as payment in full for a service, this means that a claim for that service is an Unassigned Claim.

If you receive a service for which the claim is an Assigned Claim, Blue Cross Blue Shield will not pay any amount towards the claim, since the provider has agreed to accept the Medicare provided amount. If you receive a service for which the claim is an Unassigned Claim, Blue Cross Blue Shield will pay the difference between the Medicare approved amount and the amount Blue Cross Blue Shield normally pays for covered services as if you were an Actively at Work Participant.

For Unassigned Claims, Medicare pays you the Medicare approved amount and Blue Cross Blue Shield pays you the difference between the Medicare approved amount and the amount approved by Blue Cross Blue Shield, if any. You are responsible for paying the provider’s charge. The provider may charge you more than the Medicare or Blue Cross Blue Shield approved amounts, and you will be responsible for paying the provider the difference between the Medicare approved amount and the Blue Cross Blue Shield approved amount.

For services provided out of state, covered benefits will vary based upon whether the provider participates with a Blue Cross Blue Shield plan and whether the provider accepts Medicare assignment. See the **Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Regardless of what Medicare pays, Blue Cross Blue Shield will not pay for anything that would not be covered if you were an Actively at Work Participant.

If Medicare does not cover a specific service or supply, Blue Cross Blue Shield will cover such service or supply if it is a covered benefit for a Member without Medicare.

All benefits provided under the Supplement to Medicare Program are subject to the Coordination of Benefits (COB) provisions as described in Section 22, Coordination of Benefits and Subrogation, of this SPD.

The above is a summary of benefits. Medicare benefits are subject to final interpretation of the Department of Health and Human Services.

Miscellaneous Benefits

In addition to the Supplemental Coverage provided by Blue Cross Blue Shield, will the Fund continue to pay vision and dental and other Miscellaneous Benefits?

Yes, the Fund will continue to pay the same Miscellaneous Benefits it paid for you as an Actively at Work Participant, except for Loss of Time Benefits, Accidental Death and Dismemberment Benefits and Life Insurance Death Benefits.

The Trustees always retain the right to change this and any other benefit under the Plan.

Method of Payment for Coverage

Will premiums for Supplemental Coverage be deducted from my pension Benefit?

Yes. You as a retired Participant will have self-payments deducted from your UA Local 190 Pension Fund benefit check. If your self-pay coverage is terminated, cancellation of the deductions must be made in writing at least 60 days before the effective date of cancellation.

How do I pay for Supplemental Coverage if for some reason it can't all be deducted from my pension Benefit?

Please see **Section 19, Self Pay Rules**, which apply to your self-pay requirement.

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 Administrative Manager's Office.

Provisions for Continued Participation

How do I continue Supplemental Coverage?

You as a retired Participant may continue your coverage under the Supplement to Medicare Program for yourself until one of the following occurs:

- You fail to remit self-payments on time or in the proper amount.
- You fail to remain a Member in good standing with Local 190.
- The termination of the Supplement to Medicare Program.
- The death of the retired Participant. In the event of your death, your Surviving Spouse may continue coverage under either the Surviving Spouse Self-Payment Program or COBRA Continuation of Coverage.
- You lose your Medicare coverage. If you lose your Medicare coverage, you must immediately notify the Administrative Manager's Office to make arrangements for continued coverage under the appropriate Self-Payment or Actively at Work Participant Program, provided you meet the qualification for participation in one of those programs. Coverage may also be provided under COBRA Continuation of Health Coverage.

Coverage may be continued for your eligible Spouse and Children under the Retiree Self-Payment Program. The rules for continuation of coverage for your Spouse and Children are the same as for continuation of coverage as a retired Participant. See **Section 19, Self Pay Rules**.

End Stage Renal Disease

If I have End Stage Renal Disease (ESRD), how does the Plan coordinate with my Medicare coverage?

We will coordinate our payment with Medicare for all covered services used by Members with ESRD, including hemodialysis and peritoneal dialysis. Therefore, it is important that Members with ESRD file a valid application for Medicare with the Social Security Administration. Dialysis services must be provided in a hospital, a participating freestanding ESRD facility or in the home.

When Medicare Coverage Begins

For Members with ESRD, Medicare coverage begins the first day of the fourth month of dialysis, provided you file a valid application for Medicare with the Social Security Administration.

Example: Dialysis begins February 12. Medicare coverage begins May 1.

The period before Medicare coverage begins (up to three months) is the Medicare waiting period.

If you begin a self-dialysis training program in the first three months of your regular course of dialysis, the Medicare waiting period is waived. In this case, Medicare coverage begins on the first day of the month in which you begin your regular course of dialysis.

If you are admitted to a Medicare-approved hospital for a kidney transplant or for related health care services you need prior to a transplant, Medicare coverage begins on the first day of the month in which you are admitted to the hospital. Your transplant must take place that month or within the following two months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or for related health care services you need prior to the transplant, Medicare coverage begins two months before the month of your transplant.

When Blue Cross Blue Shield Coverage is the Primary or Secondary Plan

If your Blue Cross Blue Shield group coverage is provided through an employer and you are entitled to Medicare because you have ESRD, your Blue Cross Blue Shield coverage is your primary plan for all covered services for up to 33 months, which includes the three-month (maximum) waiting period and the 30-month coordination period. (A medical evidence report may be used to establish the coordination period.) After the 30-month coordination period ends, Blue Cross Blue Shield is your secondary plan and Medicare is your primary plan.

Dual Entitlement

If you have dual entitlement to Medicare **and** have employer group health plan benefits, the following conditions apply:

- If entitlement based on ESRD occurs at the same time as or prior to entitlement based on age or disability, the plan provided by the employer group is the primary plan through the end of the 30-month coordination period.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. You start a regular course of dialysis on June 12, 2011, and on September 1, 2011, you become entitled to Medicare because you have ESRD. In February 2012 you become entitled to Medicare because you turn 65. In this situation, even though you turn 65 during the 30-month coordination period, your employer's plan will be your primary plan for the entire 30-month coordination period from September 1, 2011, through February 2014. Your employer's plan will be your secondary plan starting March 1, 2014.

- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:

- If you are a working aged or working disabled individual in your first month of dual entitlement, the plan provided by your employer group is your primary plan and remains your primary plan through the end of the 30-month coordination period. Because you are working and not a retiree, although you are Medicare-eligible, your prescription medicine costs will count toward the TrOOP annual out-of-pocket limit.

Example: You became entitled to Medicare in June 2011, when you were 65 years old. You have coverage through your employer's plan and, because you are still working, your employer's plan is your primary plan. On May 27, 2013, you are diagnosed with ESRD and begin a regular course of dialysis. On August 1, 2013, you become entitled to Medicare because you have ESRD. Your employer's plan remains your primary plan for the 30-month coordination period, from August 1, 2013, through January 31, 2016. Medicare becomes your primary plan on February 1, 2016. Because you are not a retiree, your prescription medicine costs will count towards the TrOOP annual out-of-pocket limit.

- If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. In August 2011, when you turn 65, you become entitled to Medicare. In January 2012 you begin a regular course of dialysis. On April 1, 2012, you become entitled to Medicare because you have ESRD. Because Medicare was already your primary plan when you became dually entitled, Medicare will remain your primary plan both during and after the coordination period.

SECTION 18

PREAPPROVAL AND PRECERTIFICATION

If I have to go into the hospital and/or have surgery, do I have to find out what my hospital and surgeon will charge or get a second opinion or prior Trustee approval to make sure my coverage will pay the bill?

If you are using a participating provider for Basic Benefits, the doctor has agreed in advance to the payment to be made by Blue Cross Blue Shield, and the doctor cannot bill more. However, if you are not using a participating provider, then Blue Cross Blue Shield will only pay what it determines is the fair price for the service in the geographic area of the service. If this is less than the doctor charges, which it usually is, then the Fund will pay up to its reasonable and customary limits. After that, you will be responsible for the balance. You no longer have to get a second opinion or prior approval of the Trustees for Basic Benefits.

Under this Plan, precertification is generally required only if you enter an inpatient long-term acute care hospital or use a noncontracted hospital under certain circumstances. This is explained in Section 8, Health Care Coverage - Basic Benefits. For more information on these precertification requirements, see the **detailed Benefit Schedule** available upon request from the Administrative Manager at no cost to you, or contact your Blue Cross Blue Shield customer service representative.

Preapproval may be required to be obtained by your provider for certain procedures or items of coverage. A participating provider is aware of which items require preapproval at the provider level and is responsible for contacting Blue Cross Blue Shield when appropriate.

You always have the right to obtain whatever health care you and your health care provider decide is best for you. Blue Cross Blue Shield and the Trustees have the right only to determine what will and will not be paid under the coverage provided by this Plan.

Do medicines administered by providers require pre-approval?

Medications on Blue Cross Blue Shield's select specialty pharmaceutical list will be covered by the Plan as a Basic Benefit only if the medication is **pre-authorized**. These are a select group of medicines administered by injection or infusion in a physician's office, a clinic, or a patient's home. Pre-authorization is a method of managing the use of these medicines and making sure they are used only when use is appropriate under Blue Cross Blue Shield criteria. This means that your physician or other professional provider must contact Blue Cross Blue shield in advance of the medicine's administration and obtain Blue Cross Blue Shield's approval. Blue Cross Blue Shield establishes specific criteria that must be met before approval will be granted. The criteria vary from medication to medication, and are designed to make sure that these specialty pharmaceuticals are administered only in appropriate cases.

Are there any pre-approval requirements for prescription medicines?

In some cases, BCBSM may require your physician to seek pre-approval before filling prescriptions for certain medications. If the pre-approval is denied, an alternative prescription medicine or therapy may be offered. If BCBSM denies coverage for a particular medicine, the Fund generally will not pay for that medication.

If you have any questions regarding pre-approval requirements for prescription medicines, call BCBSM at the number shown at the end of this document.

SECTION 19

SELF PAY RULES

This is a summary only. You must look to the detailed description of self-pay eligibility rules of Sections 2 through 6 for the specifics of eligibility. Monthly self-pay premiums may be changed by the Trustees effective before you receive a new SPD. Contact the Administrative Manager for current rates.

Eligibility Group	**Period Eligible**	**Coverage**	**Monthly Self Pay Premium ***
Bargaining unit employee participant	If on out of work list, 12 months at reduced rate (initial 12 month period counted against total 18 or 36 month "COBRA" coverage period). If not on out of work list, see "COBRA" Eligibility Groups, below.	Full Medical and Dental per Plan, Life Insurance, Misc. Benefits, Loss of Time	$100.00 per month
Bargaining unit employee participant	After first 12 month period expires (see above), 6 or 24 months (the remaining "COBRA" coverage period) at full "COBRA" rate unless Special Exception to Full COBRA rate applies. See "COBRA" Eligibility Groups, below, for applicable full "COBRA" rate.	Full Medical and Dental per Plan, Misc. Benefits	See COBRA Monthly Self Pay Premium, below, for Eligibility Group (single, couple, family)
Non-bargaining unit employee	Ineligible for self-pay except under "COBRA" Continuation. See "COBRA" Eligibility Groups, below, for applicable full "COBRA" rate.	N/A	N/A
Surviving Spouse, with family **	Indefinite	Full Medical and Dental per Plan, Misc. Benefits	$439.66 per month***
Surviving Spouse, without family **	Indefinite	Full Medical and Dental per Plan, Misc. Benefits	$320.31 per month***
Retiree, before age 60:	To age 60	Full Medical and Dental per Plan, Misc. Benefits	$531.01 per month ***
Retiree, before age 60, with Spouse on Medicare:	To age 60	Full Medical and Dental per Plan, Misc. Benefits	$457.93 per month ***
Retiree, age 60-65:	To age 65	Full Medical and Dental per Plan, Misc. Benefits	$405.56 per month***
Retiree, age 60-65, with Spouse on Medicare:	To age 65	Full Medical and Dental per Plan, Misc. Benefits	$326.39 per month***

Eligibility Group	Period Eligible	Coverage	Monthly Self Pay Premium *
Medicare Retiree (65 or otherwise) with Spouse not on Medicare, under Medicare Retiree Plan:	Indefinite	Supplemental Medical (Retiree), Full Medical (Spouse) and Dental per Plan, Misc. Benefits	$326.39 per month***
Medicare Retiree (65 or otherwise) with a family not on Medicare, under Medicare Retiree Plan:	Indefinite	Supplemental Medical (Retiree), Full Medical (Family) and Dental per Plan, Misc. Benefits	$405.56 per month***
Medicare Retiree, Medicare Spouse or Medicare Surviving Spouse only, under Medicare Retiree Plan:	Indefinite	Supplemental Medical, Dental per Plan, Misc. Benefits	$84.03 per month (each) ***
COBRA, full coverage, single	18 or 36 months	Full Medical and Dental per Plan, Misc. Benefits	$647.00 per month*
COBRA, full coverage, couple	18 or 36 months	Full Medical and Dental per Plan, Misc. Benefits	$1,425.00 per month*
COBRA, full coverage, family	18 or 36 months	Full Medical and Dental per Plan, Misc. Benefits	$1,846.00 per month*
COBRA, basic coverage, single	18 or 36 months	Full Medical per Plan, Misc. Benefits, No Dental	$626.00 per month*
COBRA, basic coverage, couple	18 or 36 months	Full Medical per Plan, Misc. Benefits, No Dental	$1,379.00 per month*
COBRA. basic coverage, family	18 or 36 months	Full Medical per Plan, Misc. Benefits, No Dental	$1,787.00 per month*
Participant on Workers' Compensation	First 12 months at indicated rate; Second 12 months at indicated rate; Third 12 months at indicated rate. All periods on Workers' Compensation run concurrently with and count against the total 18 or 36 month "COBRA" coverage period	Full Medical and Dental per Plan, Misc. Benefits	$100.00 per month for the first 12 months; $200.00 per month for the second 12 months; and $300.00 per month for the third 12 months.

Eligibility Group	Period Eligible	Coverage	Monthly Self Pay Premium *
Disabled Participant not receiving Pension Plan Disability	12 months at indicated rate (initial 12 month period counted against total 18 or 36 month "COBRA" coverage period) followed by 6 or 24 additional months (the remaining "COBRA" coverage period) at full "COBRA" rate, unless Special Exception to Full COBRA rate applies. See "COBRA" Eligibility Groups, above, for applicable full COBRA rate.	Full Medical and Dental per Plan, Misc. Benefits,	$100.00 per month for the first 12 months; COBRA Full Coverage rate thereafter
Disabled Participant not receiving Pension Plan Disability, following 12 months at reduced rate, only if special exception is granted by the Trustees	6 or additional 24 month period (the remaining "COBRA" coverage period) following initial 12 month period	Full Medical and Dental per Plan, Misc. Benefits	$100.00 per month
Disabled Participant receiving Pension Plan Disability and Social Security Disability	Duration of Pension Plan Disability	Full Medical and Dental per Plan, Misc. Benefits	Same as rates for Retiree (and spouse or family), age 65***
Disabled Participant receiving Pension Plan Disability, not on Social Security Disability, Single	Duration of Pension Plan Disability	Full Medical and Dental per Plan	$152.24 per month***
Disabled Participant receiving Pension Plan Disability, not on Social Security Disability, with spouse or family not on Medicare	Duration of Pension Plan Disability	Full Medical and Dental per Plan	$405.56 per month***
Disabled Participant receiving Pension Plan Disability, not on Social Security Disability, with spouse on Medicare	Duration of Pension Plan Disability	Full Medical and Dental per Plan	$326.39 per month***

* Subject to periodic review and change by Trustees; prices are as in effect March 1, 2016; however, COBRA rates will be adjusted each March 1 based on actual costs of coverage

** Surviving Spouse of either a Member or Non-Bargaining Unit Employee

*** Subject to increase on each March 1 following increase in single person basic coverage COBRA rate; increase determined by multiplying rate in effect by a fraction, the numerator of which is the new single person basic coverage COBRA rate and the denominator of which is the preceding year's single person basic coverage COBRA rate

Method of Payment for Coverage

If I have to make self-payments for coverage, how do I do it?

Self-payments are due in the Administrative Manager's Office on the last day of the month for which payment is being made. For example, if August hours are below the 100 required hours, the self-payment to provide coverage for the month of October is due in the Administrative Manager's Office no later than October 31.

Self-payments must be made by check or money order made payable to:

UA Local 190 Health and Welfare Fund

and sent to the Administrative Manager's address at the end of this document.

In addition, self-payments may be paid from your Individual HRA balance if you have sufficient funds available, but you must file an Individual HRA Reimbursement Request Form with the Fund Office before the self payment is due – this will not happen automatically. Note that you cannot use your Benefit Advisor Card to make self-payments.

If you are retired and are receiving a Pension Benefit, self-payments will be deducted from your UA Local 190 Pension Fund monthly benefit check.

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 Administrative Manager's Office.

Provisions for Continued Participation Under Self-Payment Programs

How long can I continue my coverage under self-payment provisions and how might my coverage be terminated?

As a self-pay Participant, subject to the eligibility periods listed above, you can continue your coverage under a Self-Payment Program until one of the following occurs:

- You fail to remit your self-payments on time or in the proper amount.
- You fail to remain a Member in good standing with Local 190.
- You attain age 65 or otherwise become eligible for Medicare benefits (in which case you may be eligible for Supplemental Coverage).
- The Trustees terminate the Self-Payment Program in which you are participating.
- You reach the end of the eligibility period for the Self-Payment Program in which you are participating.
- You otherwise become ineligible for the Self-Payment Program in which you are participating.

As a self-pay Participant, you may continue coverage for your Spouse and/or Children under this program until one of the following events occurs:

- You fail to remit your self-payment on time or in the proper amount.
- You fail to remain a Member in good standing of Local 190.
- You become eligible under Medicare, except that if your Spouse is not eligible for Medicare, you may continue coverage for your Spouse and any Children under the Self-Payment Program until they do become eligible for Medicare. Coverage may also be available under COBRA Continuation of Coverage.
- Your Child or Children no longer meet the definition of a Child under the Plan. You, as a self-pay Participant, your Spouse, or your Child must notify the Administrative Manager's Office, in writing, within 60 days following the date your child no longer qualifies as a Child in order to be offered COBRA Continuation of Coverage.
- The Trustees terminate the Self-Payment Program in which you are participating.

- You reach the end of the eligibility period for the Self-Payment Program in which you are participating.

- You otherwise become ineligible for the Self-Payment Program in which you are participating.

- Your Spouse no longer meets the definition of eligible Spouse. You, as a self-pay Participant, or your Spouse, must notify the Administrative Manager's Office, in writing within 60 days following the date your Spouse no longer qualifies as a legal Spouse in order to be offered COBRA Continuation of Coverage.

- Your death. In the event of your death as a self-pay Participant your Spouse and Children may continue coverage under either the Surviving Spouse and Children Self-Payment Program or COBRA Continuation of Coverage.

Note: If you retire, and you do not cover your Spouse at that time, you cannot add that Spouse later.

Special Provisions

What happens if I stop making my self-pay payments?

If you as a self-pay Participant decide to stop paying self-payments or you fail to pay your self-payment on time, 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 other than the COBRA notice, if applicable. You will not then have an opportunity to participate in the Plan under the Supplement to Medicare Program at the age of 65, unless you meet the qualifications of that program and the Trustees approve your coverage.

What if I return to work after being a self-pay Participant?

If you as a self-pay Participant return to active work at the trade for a covered Employer, you may continue to make self- payments under this program until you satisfy the eligibility provisions of the Actively at Work Program. It is your responsibility as a self-pay Participant to notify the Administrative Manager's Office, in writing, if you return to work and to again notify the Administrative Manager's Office, in writing, when you again retire or otherwise terminate your employment.

SECTION 20

COBRA CONTINUATION OF HEALTH COVERAGE

What if my* Spouse*, a Child, or I lose our health coverage?

Under a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, referred to as COBRA, you and your Spouse and Children may be able, as self-pay Participants, to continue your Basic Benefits for a period of time. (See **How long will coverage last?**) The benefits that can continue are only the medical, hospital, dental, Miscellaneous Benefits, Prescription Medicine, Individual HRA and EAP. You can't continue any other Benefits such as an Accidental Death or Dismemberment Benefit, Life Insurance Death Benefit or a Loss of Time Benefit.

If any of the events occur that terminate your eligibility for coverage under the Plan, and you or your Spouse or Children are covered at the time of the event as a Participant in the Plan, upon notice thereof to the Administrative Manager, you will receive a COBRA notice from the Administrative Manager. The Administrative Manager will then advise you specifically whether you are eligible, and if so, how to continue your Basic Benefits and certain Miscellaneous Benefits through COBRA. If the Administrative Manager determines that you are not entitled to elect COBRA continuation coverage, the Administrative Manager will advise you of why you are ineligible.

This section provides a summary of the law and therefore is general in nature. The law itself and regulations interpreting the law must be consulted with regard to the application of these provisions in any particular circumstance.

Am I entitled to COBRA even if I leave the trade?

Yes. This is a federal right given you.

Qualified Beneficiaries and Qualifying Events

Who is covered and after what events?

Participants. You have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment, termination of your employment (for reasons other than gross misconduct), or if you are retired, certain bankruptcy proceedings.

Spouses of Participants. Spouses of Participants covered by this Plan are "Qualified Beneficiaries," and have the right to choose continuation coverage for themselves if they lose group health coverage under the Plan for any of the following five reasons:

- The death of their spouse.
- Termination of their spouse's employment (for reasons other than gross misconduct) or reduction in their spouse's hours of employment.
- Divorce or legal separation from their spouse.
- Their spouse becoming entitled to Medicare (either Part A, Part B, or both, or Part D).
- The commencement of certain bankruptcy proceedings, if their spouse is retired.

Children. Children of Participants covered by this Plan also are "Qualified Beneficiaries" and have the right to continuation coverage if group health coverage under the Plan is lost for any of the following six reasons:

- The death of the Participant parent.

- The termination of the Participant parent's employment (for reasons other than gross misconduct) or reduction in the Participant parent's hours of employment.

- Parents' divorce or legal separation.

- The Participant parent becoming entitled to Medicare (either Part A, Part B, or both, or Part D).

- The Child ceasing to be a "Child" under the Plan.

- A proceeding in a bankruptcy reorganization case, if the parent who was a Participant is retired.

A Child born to, or placed for adoption with, the covered Participant during a period of continuation coverage also is a Qualified Beneficiary.

Separate elections. Each person who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a Spouse or Child is entitled to elect continuation of coverage even if the covered Participant does not make that election. Similarly, a Spouse or Child may elect a different coverage from the coverage that the Participant elects (for example, full coverage instead of basic coverage.

Elections

When must an election be made for COBRA continuation coverage?

Election Period. Election of continuation coverage must be made within 60 days of the later of the date coverage would terminate under the Plan due to the qualifying event or the date of the Qualifying Event Notice. If election of continuation coverage is not made within this 60-day period, you will lose your right to elect continuation coverage under COBRA.

Self-payment coverage is available under certain circumstances at rates lower than the full COBRA continuation coverage rate. This self-payment coverage counts against the total period of COBRA continuation coverage. To qualify for the lower rate, election of self-payment coverage must be made within certain time periods – generally by the 20th day of the month for which the first self-payment must be made. If this deadline is missed, COBRA continuation coverage at the full COBRA rate will still be available until the end of the 60-day election period described above.

EXAMPLE:

> Assume a Member works less than 100 hours in April. To qualify for the lower self-payment rates, the Member must pay the self-payment premium by June 20, the 20th day of the coverage month related to April hours. This deadline applies regardless of when notice is sent to the Member.
>
> Coverage is normally cancelled on June 1 under these circumstances if self-payment is not made. Assume that the date of the Qualifying Event Notice is May 5. Since the date coverage would terminate due to the 100-hour rule is June 1, even if the Member fails to elect the lower self-payment rate by June 20, the Member has until 60 days after June 1, or July 31, to elect continuation coverage under COBRA; but because the election was not made by June 20, the Member must pay the full COBRA continuation rate. If for some reason the date of the Qualifying Event Notice was later than June 1, the Member would have until 60 days after the date of the Qualifying Event Notice to elect continuation coverage under COBRA; but because the election was not made by June 20, the Member must pay the full COBRA continuation rate.

Payments

How much must I pay for COBRA coverage?

The Trustees determine the actual cost to the Plan that you must pay for COBRA coverage. COBRA rates are based on the actual expenses of the Plan and are adjusted annually. That is why they are higher than the rates under the other self-pay programs under the Plan. You should elect to participate in one of the self-pay programs described in **Section 19, Self Pay Rules**, if you are eligible.

When must payments be made for COBRA continuation coverage?

Due Date of First Payment. The first payment may, but need not be, sent with the Election Form. The first payment is due within 45 days of the date the election is made. You must make your first payment for continuation coverage not later than 45 days after the date or your election, or you will lose all continuation coverage rights under the Plan. You are responsible for making sure the amount of your first payment is correct according to the notice that is provided to you. The initial premium due will include payment for coverage from the time coverage is lost due to the qualifying event, through each subsequent month which has passed and through the month which has started by the time you make the initial payment.

Periodic Payments. All other premiums are due on or before the first of each month for that month's coverage period. A thirty (30) day grace period will be allowed for each monthly payment but if the premium is not received within thirty (30) days of the due date, all options, rights and benefits under this continuation provision and under the Plan will terminate automatically. There are no reinstatement privileges and no claim will be paid if it is incurred during any period for which premiums have not been paid. The Plan will not send periodic notices of payments due.

Payment of Amounts Less Than the Full Premium. If timely payment is made to the Plan in amount that is less, but not significantly less than the amount due (if it is no greater than the lesser of $50.00 or 10% of the amount due), the Plan Administrator will notify you of the amount of the deficiency. You will then have a period of 30 days from the date of notice is provided in which to make up the deficient payment. If timely payment is made to the Plan in an amount that is significantly less than the amount due, the Plan Administrator will not provide notice of the amount of any deficiency. In this case, if you do not make up the deficient premium by the original due date of the applicable coverage period, your continuation coverage will terminate as stated under the section below entitled, **Continuation Coverage may be Cut Short.**

Your Responsibility to Notify the Plan

What events must I tell the Plan about?

Under the law, the Participant or a family member has the responsibility to inform the Administrative Manager of a divorce, legal separation, or a Child losing Child status under the Plan, within 60 days of the date of the event. In addition, the Participant or a family member must inform the Administrative Manager of a determination by the Social Security Administration that the Participant or covered family member was disabled during the 60-day period after the Member's termination of employment or reduction of hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. (See **Special Rules for Disability,** below). If, during continuation coverage, the Social Security Administration determines that the Member, or family member is no longer disabled, the individual must inform Administrative Manager of this redetermination within 30 days of the date it is made.

Coverage Choices

What kind of coverage can I obtain?

If you choose continuation coverage, the Plan is required to allow you to purchase coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Participants or family members. This means that if the coverage for similarly situated Participants or family members is modified, your coverage will be modified. ("Similarly situated" refers to current Participants or their Spouses and/or Children who have not had a qualifying event.)

You also will have the right to choose only the "basic" health coverage (Basic Benefits, Miscellaneous Benefits, and Prescription Medicine Benefits), or the "full coverage" option (Basic Benefits, Miscellaneous Benefits, Prescription Medicine Benefits, and Dental). You cannot pick and choose among the health coverage components.

When Coverage Ends

How long will coverage last?

You can maintain continuation coverage for 18 months (if you lost group health coverage because of a termination of employment or reduction in hours) or 36 months (if you lost group health coverage because of any other qualifying event).

If another qualifying event occurs while you are in an 18-month period of continuation coverage, it may be that your continuation coverage will be extended to a total of 36 months. In no event will such coverage extend beyond 36 months from the date of the initial qualifying event. You should notify the Administrative Manager if a second qualifying event occurs during your continuation coverage period within the later of 60 days of the date of the second qualifying event or 60 days of the date the qualifying beneficiary would lose coverage under the Plan as a result of the qualifying event.

Continuation coverage may be cut short. The law provides that a covered individual's continuation coverage may be cut short prior to the expiration date of the 18-, 29-, or 36-month period for any of the following five reasons:

- This Plan no longer provides group health coverage to any Participants.
- The premium for continuation coverage is not paid in full in a timely manner (within the applicable grace period).
- Any time after the latest date that COBRA coverage may be elected under this Plan, the individual becomes covered under another group health plan (whether or not as an employee) that does not contain any exclusion or limitation with respect to any pre-existing condition of the individual (other than an exclusion or limitation that, after July 1, 1997, does not apply to, or is satisfied by, the individual under the provisions of the Health Insurance Portability and Accountability Act of 1996 or that does not apply due to PPACA effective in 2014).
- The individual becomes enrolled in Medicare (under Part A, Part B, or both, or Part D) after electing continuation coverage under this Plan.
- Coverage has been extended for up to 29 months due to disability (see **Special Rules for Disability**) and there has been a final determination that the individual is no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant, Spouse or Child not receiving continuation coverage (such as fraud).

If continuation coverage is terminated for any of the above reasons, the Plan Administrator will provide notice of such early termination of coverage, including the reasons for such termination, the date of the termination and any rights a qualified beneficiary may have to elect any alternative coverage.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay the premium for your continuation coverage.

Special rules apply if you or covered family members are disabled during continuation coverage. Please read the following subsections regarding these situations.

When my continuation coverage ends, can it be reinstated?

Once your continuation coverage terminates for any reason, it cannot be reinstated.

What happens if I don't choose continuation coverage?

If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end.

However, if you decline enrollment in continuation coverage for yourself, your Spouse or your Children because of other health insurance coverage, you may in the future be able to enroll yourself, your Spouse and your Children in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Spouse or Child as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your Spouse and your Children, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Special Rules for Disability

What special rules apply if a covered person becomes disabled?

Special rules for disability. If you or a covered family member are disabled at any time during the first 60 days of continuation coverage, the continuation coverage period is 29 months for all family members, even those who are not disabled. The Social Security Administration must determine the disability that extends the continuation coverage period. The Participant or family member must inform the Administrative Manager within 60 days of the date of disability determination and before the end of the original 18-month continuation coverage period. If, during continuation coverage, the Social Security Administration determines that a Participant or family member is no longer disabled, the individual must inform the Administrative Manager of this redetermination within 30 days of the date it is made. In this case, coverage will not extend beyond the initial 18 month period, and if it has already continued beyond that period, coverage will end on the later of the first day of the month that is more than 30 days after the date of a final determination by the Social Security Administration that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's being entitled to the disability extension is no longer disabled. If a Participant or family member is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction of hours.

Premium for period of disability extension coverage. If you become entitled to an extension in COBRA continuation coverage beyond the original 18 month period due to a disability as described above, the premium for continued coverage will increase to 150% of the cost of coverage, subject to any annual adjustments of costs imposed by the Trustees on COBRA rates, for the 19th month through the 29th month of COBRA continuation coverage. If a second qualifying event occurs as described above, this increased premium will remain in effect up to 36 months from the date of the original qualifying event. However, if a second qualifying event occurs during the first 18 months of coverage, the premium will remain at the same level throughout the entire 36 months of COBRA continuation coverage, without regard to a beneficiary's disability, subject to any annual adjustments of COBRA costs.

SECTION 21

FILING CLAIMS AND APPEALS

This section explains the rules for filing claims and appealing a benefit denial.

Authorized Representatives

Any reference in these procedures to "you" or the "Member" is also a reference to your or the Member's authorized representative making a claim on your behalf or the Member's behalf. The Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf or the Member's behalf.

Insured Benefits vs. Fund Benefits

Are the benefits under this Plan insured, or are they paid directly from the Fund?

Some of the benefits are insured, which means that we pay premiums to an insurance company, which then takes full responsibility for paying the full amount of the claims. The insured benefits are:

- Life Insurance Benefit.
- Accidental Death and Dismemberment Benefit.
- Magellan HRSC, Inc. Employee Assistance Program.

Other benefits are paid directly by the Fund from the accumulated employer and self-pay contributions and any investment earnings on those contributions. The benefits subject to this funding method are:

- Basic Benefits.
- Miscellaneous Benefits.
- Prescription Medicine Benefits.
- Individual HRA (paid from the Individual HRA Plan and Trust).
- Loss of Time Benefits.
- Delta Dental.

The Fund may also purchase insurance (called "stop-loss" insurance) to protect the Fund itself from Basic Benefit claims in excess of certain limits. This insurance is not payable to Members; it is paid to the Fund itself.

Are claims handled differently for benefits that are insured and benefits that are paid directly by the Fund?

Yes. Claims for insured benefits are forwarded to the insurance company that insures the benefit and are subject to the appeals and review procedures of the insurance company. The Trustees have no power over appeals for benefits relating to insured benefits.

Miscellaneous Benefits, Prescription Medicine Benefits and Individual HRA claims are initially processed through the use of your Benefit Advisor Card (in conjunction with the BCBSM Card for Prescription Benefits). For claims incurred with service providers that do not accept VISA and other claims that are not paid through the Benefit Advisor Card, the Administrative Manager processes initial claims for all of the uninsured benefits other than Basic Benefits and Delta Dental. Appeals relating to these claims are handled by the Trustees.

Other than amounts paid by use of the Benefit Advisor Card, the Administrative Manager handles claims for uninsured benefits other than Basic Benefits and Delta Dental directly, subject to appeals to the Trustees. Blue Cross Blue Shield handles claims for Basic Benefits, subject to appeals to the Trustees. Delta Dental provides its own claims and appeal procedure, which is described in Section 23.

If you have a claim for an insured benefit, it should be filed directly with the insurance company. The Administrative Manager will provide claim forms for the MetLife Insurance and Accidental Death and Dismemberment Benefits upon request. Magellan HRSC, Inc. provides the Employee Assistance Plan Benefits directly using their network of providers, so claim forms should not be needed unless you exceed their maximum number of visits, in which case their services may be covered under the Miscellaneous Benefits or Basic Benefits.

If you have a claim for an uninsured benefit other than Basic Benefits or Dental and it was not eligible for payment through the use of your Benefit Advisor Card, it should be filed directly with the Administrative Manager at the address at the end of this SPD. The Administrative Manager makes an initial claims decision on these benefits, subject to appeal to the Board of Trustees. If you obtain services from a service provider that does not accept VISA, your claim is subject to these claims and appeals procedures. You must retain receipts for all services (even those automatically covered with the Benefit Advisor Card) because the Fund Office may need to request receipts to verify expenses are covered. If you cannot substantiate any payments (either through use of the Benefit Advisor Card or otherwise) with receipts, your claim will be denied and you will be required to return any related Benefit Advisor Card payments made by the Plan to the Plan.

If you have a claim for Basic Benefits, it should be filed with Blue Cross Blue Shield. Any appeal of a claims decision made by Blue Cross Blue Shield should be filed with the Administrative Manager at the address at the end of this SPD, for review by the Board of Trustees.

Claims Processor

Who processes initial claims for benefits?

The Plan Administrator has delegated the responsibility for making an initial claims decision to the following:

- The Administrative Manager for Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA Benefits and Loss of Time Benefits;
- BCBSM for Basic Benefits;
- Delta Dental for Dental Benefits; and
- For any insured benefit, the applicable insurance company.

The term "Claims Processor" as used in this section of the Plan refers to whichever of the above is making the initial claims decision.

Basic Benefits Services

If I go to a participating provider for a service covered by the Blue Cross Blue Shield Basic Benefits, do I have to file a claim with Blue Cross Blue Shield for these Basic Benefits services?

No. If you go to a participating provider, you will not have to file claims for Basic Benefits services (those administered by Blue Cross Blue Shield) because claims are submitted directly by the provider to Blue Cross Blue Shield for you and are paid by Blue Cross Blue Shield.

However, if you receive Basic Benefits services from Nonparticipating providers, or you receive care out of the state or out of the country, you may be required to pay the bills and file your own claims with Blue Cross Blue Shield for reimbursement.

How to Submit a Claim

How do I submit a claim for Basic Benefits?

You get a claim form from Blue Cross Blue Shield. The Administrative Manager may be able to assist you with getting claim forms in some cases. You should submit claims as soon as you receive covered services. Generally, if you submit claims beyond the applicable time limit, they will be denied. The time limit is 15 months after the date of service for Basic Benefits claims and 24 months after the date of service for hearing care services claims.

Procedure

What is the procedure for submitting a claim for Basic Benefits?

- Obtain itemized statements from the provider that include the following information:

  - Name of the Patient and the Subscriber's name.
  - Contract number (from your ID card).
  - Name and address of the health care provider.
  - Provider's federal tax ID number.
  - Description of services.
  - Diagnosis (nature of illness or injury).
  - Date of each service.
  - Dates of admission and discharge (if admitted to a hospital).

  NOTE: If you receive medical services out of the state or out of the country, you will need to pay the bill and get an itemized receipt. Try to have all receipts written in English and in U.S. currency.

  You may include cash register receipts, canceled checks or money order stubs with your itemized claim, but they do not substitute for an itemized receipt.

- Complete the appropriate claim form:

  - **Participant Application for Payment** form for Basic Benefits services; or
  - The **Blue Cross Blue Shield Hearing Out-of-State Claim** form for hearing care services.

  NOTE: Hearing care services claims for in-state care should never be necessary because **in-state** care must be provided by participating providers who will submit claims on your behalf

- Complete a separate claim form for each covered person. Multiple services for the same Patient may be attached to one claim form.

- Attach all itemized receipts and statements to the claim form. Make sure the Participant's name and contract number are on all receipts and attachments.

- Review all claim forms to be sure they are accurate and complete. Incomplete forms will cause your payment to be delayed. Be sure to sign and date each claim. Always keep a copy of your claims and receipts because Blue Cross Blue Shield cannot return them to you.

- Mail all claim forms to the address shown on the form. If you do not have a claim form, send the itemized receipt to:

Blue Cross Blue Shield
600 Lafayette East
Detroit, MI 48226
Attn: Department # 0734

How Payment Is Made

How is payment of my claim made?

When you send in your own claims to Blue Cross Blue Shield, you will receive the approved payment directly from Blue Cross Blue Shield. If you have not already paid the provider, it is your responsibility to do so, including the amount that may not be covered by your reimbursement check.

NOTE: When you are reimbursed for a service received out of the country, your coverage will pay the Approved Amount, at the rate of exchange in effect at the time you received care.

What To Do if a Claim is Denied by Blue Cross Blue Shield

What if my claim for Basic Benefits services is denied?

If your claim for payment is denied in whole or in part your Explanation of Benefits (EOB) will indicate the reason for the nonpayment.

You may make an appeal to the Board of Trustees under the appeal procedure that follows.

If I am required to pay a Basic Benefits co-payment or deductible, can I use the Benefit Advisor Card?

You generally cannot use Prescription Medicine Benefits or Miscellaneous Benefits to pay Co-pays or Deductibles (other than Delta Dental co-pays, which can be paid from the Miscellaneous Benefits account), but if you have money in your Individual HRA account, you can use that to pay a Basic Benefits Co-pay or Deductible expense incurred (i.e. services rendered) through the use of the Benefit Advisor Card. Use the card the same way you would use a VISA. Note that if you use your Benefit Advisor Card in a doctor's office or hospital for something that could be covered by Prescription Medicine or Miscellaneous benefits (such as filling a prescription), it will automatically use your Individual HRA account money to pay the bill instead of any Miscellaneous or Prescription Medicine funds you might have available.

Internal Claim Procedure for Uninsured Benefits: Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA and Loss of Time Benefits

How do I make a claim if the service is provided by the Fund directly, and not as an insured benefit or a Basic Benefit administered by Blue Cross Blue Shield or Delta Dental benefit?

Claims for Miscellaneous Benefits, Prescription Medicine Benefits and Individual HRA benefits are processed through the use of your Benefit Advisor Card (in conjunction with your BCBSM Card for Prescription Medicine Benefits). For services incurred with service providers that do not accept VISA, you may make claims for Miscellaneous Benefits and eligible Prescription Medicine Benefits by sending your provider's statement or itemized receipt from your provider or pharmacy to the Administrative Manager, who makes the initial claims decisions on these claims. No form is required.

Please note that if the expense for which you are requesting reimbursement is a medical or dental expense, you must provide the Administrative Manager with an Explanation of Benefits ("EOB") substantiating the expense. To be eligible for payment, all claims for reimbursements under these reimbursement funds must be submitted to the Fund by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued. The statement or receipt must show the date of service, the covered person receiving the services and a description of the service

performed. For Prescription Medicine Benefits the receipt must show the date of purchase and identify the prescription medication received. Benefit payments are subject to the Administrative Manager's acceptance of the proof provided. Claims received by the tenth of the month, if approved, will be paid by the last day of the month.

You may make a claim for Loss of Time Benefits by requesting the appropriate form and filing it with the Administrative Manager and providing proof of your inability to work because of a non-occupational Accidental Injury or sickness and proof that you are under the care of a physician. The form also may be downloaded from the Fund web site, http://www.ua190benefits.org. The Administrative Manager makes initial claims decisions for Loss of Time Benefits. Benefit payments are subject to the Administrative Manager's acceptance of the proof provided.

You may make a claim for Individual HRA benefits that are not covered by the Benefit Advisor card by getting an Individual HRA Reimbursement Request Form from the Administrative Manager and sending the form with your itemized receipt from your provider or pharmacy to the Administrative Manager. The form also may be downloaded from the Fund web site, http://www.ua190benefits.org. The Administrative Manager makes initial claims decisions for these claims. Benefit payments are subject to the Administrative Manager's acceptance of the proof provided.

Remember to save your receipts for all services (even those automatically covered with the Benefit Advisor Card) because the Fund Office may need to request receipts to verify expenses are covered. If you cannot substantiate any payments (either through use of the Benefit Advisor Card or otherwise) with receipts, your claim will be denied and you will be required to return any related Benefit Advisor Card payments made by the Plan to the Plan.

How do I file a claim for continuing injury or sickness?

If you have a continuing injury or sickness that requires regular courses of repeated treatment or qualifies for Loss of Time Benefits, and you notify the Plan within the time frames described in this section, you may be able to file one claim and have the Plan continue to pay benefits on that basis. Written notice of injury or sickness upon which a claim may be based must be given to the Administrative Manager within 90 days of the date of the commencement of the first loss for which benefits arising out of each such injury or sickness may be claimed. The Administrative Manager may, in its discretion, require claims to be filed for each treatment event.

If benefits stop because you have not provided adequate proof of loss, written proof of loss must be furnished to the Administrative Manager in case of continuing loss within 90 days after the end of the period for which the Fund provides for payment of benefits, and in case of claim for any other loss, within 90 days after the date of the loss.

In any case, written proof of loss must be furnished to the Administrative Manager by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued.

Failure to furnish notice or proof within the time provided for above will not invalidate or reduce any claim if it was not reasonably possible to furnish notice or proof within the time period provided above, and notice or proof was furnished as soon as was reasonably possible.

When the Administrative Manager receives the required notice or proof, the Administrative Manager will provide the claimant with the forms usually furnished for filing proof of loss. If the forms are not furnished within 15 days after the Administrative Manager receives notice or proof, the claimant is deemed to have complied with the notice requirements as to proof of loss upon submitting, within the time limit for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

All amounts owed for continuing loss will be paid each two weeks during any period for which the Fund is providing benefits, and any balance remaining unpaid upon termination of such period will be paid immediately upon receipt of due proof.

If you request an extension of treatment at least 24 hours before the end of the originally approved length of time or number of treatments, you will be notified of the Plan's decision 24 hours after the Plan receives the claim. Any request for such an extension involving urgent care will be decided as soon as possible, taking into account the medical circumstances.

What other rules apply to claims?

Benefits for loss of life, if any, will be paid to the covered person's Beneficiary. All other benefits provided under the Plan are payable to the covered person.

The Fund will have the right and opportunity to have the person whose injury or sickness is the basis of the claim examined by a licensed physician when and so often as it may reasonably require while any claim is pending.

No lawsuit may be brought to recover benefits before completion of the Appeals Procedure and in no case before the expiration of 60 days after proof of loss has been filed in accordance with the notice requirements, nor may a lawsuit be brought after two years from the time within which proof of loss is required.

You have the sole right to select your own physician, surgeon and hospital, and a physician-patient relationship shall be maintained.

The Plan is not a replacement for and does not affect any requirements for coverage by Workers' Compensation insurance.

Timing of Initial Decision and Calculating Time Periods

How long does the Claims Processor have to decide whether a claim should be paid?

The period of time within which a benefit determination is required to be made will begin at the time a claim is filed in accordance with the procedures set forth below, without regard to whether all of the information necessary to make a benefit determination accompanies the filing. If a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

General Claims

The following claims procedure will apply to claims other than insured benefits, claims made for health benefits, and claims for Loss of Time benefits under the Plan.

Under normal circumstances, within 90 days after the Administrative Manager receives your claim for benefits, the Claims Processor will notify you, in writing, about its decision on your claim. If special circumstances require longer than 90 days to process the claim, the Claims Processor may take up to another 90 days to send you a notice of its decision. In that case, the Claims Processor will send you a written notice of the need for an extension before the end of the first 90-day period. The notice will include the reason for the extension and the date by which a final decision is expected to be made.

Loss of Time Claims

The following claims procedure will apply specifically to claims made for Loss of Time benefits.

If a claim for Loss of Time benefits is denied in whole or in part, you or your beneficiary will receive written notification within a reasonable period of time, but no later than 45 days after the Claims Processor's receipt of the claim. The Claims Processor may extend this period for up to 30 additional days provided the Claims Processor determines that the extension is necessary due to matters beyond the Claims Processor's control and the Member is notified, before the end of the initial 45-day period, of the circumstances requiring the extension and of the date by which the Claims Processor expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Processor determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Processor expects to render a decision. Any extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information.

Medical Claims

The following claims procedure will apply specifically to claims made for group health plan benefits (Basic Benefits, Dental Benefits, Miscellaneous Benefits, Prescription Medicine Benefits and Individual HRA Benefits).

Urgent Claims That Require Immediate Action

"Urgent Care Claims" are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible taking into account the medical exigencies, but not later than 72-hours after the Claims Processor receives all necessary information.

- Notice of denial may be oral with a written confirmation to follow within 3 days.

If you filed an Urgent Care Claim improperly, the Claims Processor will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Processor will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

In determining whether a claim is urgent, the Claims Processor will defer to the determination of a Member's attending provider.

You will be notified of a determination no later than 48 hours after:

- The Claim Processor's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Special Rules for Concurrent Decisions

1. Member's request to extend previously approved course of treatment.

Urgent care. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and a request to extend the treatment is an Urgent Care Claim, the request will be decided by the Claims Processor within 24 hours of the receipt of the request, provided the request is made at least 24 hours prior to the end of the approved treatment. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described below.

Non-urgent care. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and a request to extend treatment is not an Urgent Care Claim, the request will be considered a new claim and decided according to the post-service or pre-service timeframes described below, whichever applies.

2. Plan reduces or terminates a previously approved course of treatment.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan reduces or terminates the course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the reduction or termination will be considered a Claim Denial (as defined below) and you will be notified of the reduction or termination (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Pre-Service Claims

"Pre-Service Claims" are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Claim Processor within a reasonable period of time, but not later than 15 days, following the receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Processor will notify you of the improper filing and how to correct it within 5 days of receipt of the Pre-Service Claim.

The Claims Processor will notify you of its determination within 15 days after the claim is received, unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Claims Processor expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Claims Processor or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, the Claims Processor will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension will not exceed 15 days from the end of the initial 15 day period.

When will I be notified?

- Generally, only long term acute care facility services, certain noncontracted hospital services, and certain prescription medicines require approval before you receive the benefits.

- There is no requirement that you seek advance approval for Miscellaneous Benefits, Prescription Medicine Benefits, or Individual HRA benefits under the Plan, <u>except</u> when the expense is for a prescription medicine on BCBSM's pre-authorization list. Most treatment that would be needed on an urgent basis will fit the criteria for Miscellaneous Benefits, so you should not seek advance approval of Miscellaneous Benefit coverage if treatment is needed in an emergency.

- However, if you ever are uncertain about whether an expense you will incur is eligible for reimbursement as a Miscellaneous Benefit, you can request an advance determination. This would make sense only if the treatment in question was optional and not immediately required. We have tried to provide you with lots of examples in this SPD of the types of expenses that are or are not eligible, but the final decision as to whether something is eligible for Miscellaneous Benefit coverage is up to the Claims Processor or, if appealed, the Board of Trustees.

Post-Service Claims

"Post-Service Claims" are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice of the claim decision (whether or not adverse) from the Claims Processor within a reasonable period of time, but not later than 30 days, following the receipt of the claim, as long as all needed information was provided with the claim.

The Claims Processor will notify you of its determination within 30 days after the claim is received, unless the Claims Processor determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Claims Processor expects to render a decision shall be furnished to you prior to the end of the initial 30-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Claims Processor or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, the Claims Processor will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension will not exceed 15 days from the end of the initial 30-day period.

Appeals Procedure

Can I appeal a denial?

Yes. If your claim for coverage for Basic Benefits, Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA Benefits or Loss of Time Benefits is denied by the Claims Processor (either the Administrative Manager, BCBSM or Delta Dental), you have the right to a full and fair review by the Board of Trustees.

General Procedures

The following appeals procedure will apply to claims made for benefits under the Internal Claims Procedures.

- The Plan must allow you to review the claim file and to present written evidence as part of the internal claims and appeals process.

- Any decision regarding hiring, compensation, termination, promotion or similar matters with respect to an individual such as a claims adjudicator or a medical expert must not be based upon the likelihood that the individual will support a denial of benefits.

- The Board of Trustees will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the group health plan (or at the direction of the Board of Trustees) in connection with your claim; this evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Claim Denial is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give you a reasonable opportunity to respond prior to that date.

- Before the Board of Trustees can issue a Final Internal Claim Denial based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Claim Denial is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give you a reasonable opportunity to respond prior to that date.

"Claim Denial" Defined

For purposes of these review procedures, a "Claim Denial" means:

- A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a benefit under the Plan;
- This includes denials based on a determination that you are ineligible to participate in the Plan;
- For medical benefits, it also includes a denial from the application of any utilization review (a review of your request for a benefit, confirmation that the benefit is covered and confirmation that the treatment would be or was effective);
- For medical benefits, it also means a failure to cover an item or service that would otherwise be provided and is not provided because it is found experimental or investigational or not medically necessary or appropriate;
- It also means a rescission of coverage (a cancellation or discontinuance of coverage that is retroactive (applies back to a date in the past)).
- It does not mean a cancellation of coverage that is prospective (applies in the future); and
- It does not mean a cancellation or discontinuance of coverage that is retroactive if it is due to a failure to timely pay required premiums or contributions for coverage.

Notice of Initial Claim Denial

If your claim is wholly or partially denied, or you experience a rescission of coverage, the Claims Processor will furnish you with a written notice of the Claim Denial. The written notice will set forth the following information, in a manner calculated to be understood by you:

(a) The specific reason or reasons for the Claim Denial;

(b) Specific reference to those Plan provisions on which the Claim Denial is based;

(c) A description of any additional information or material necessary to perfect the claim and an explanation of why such material or information is necessary;

(d) Appropriate information as to the steps to be taken if you wish to submit the claim for review;

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Claim Denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

(f) If the Claim Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(g) In the case of a Claim Denial by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(h) A statement indicating that you will be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

(i) In the case of a Claim Denial:

- The Plan must ensure that any notice of Claim Denial includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable).

- You will be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice will contain a statement to such effect.

- The Plan must ensure that the reason or reasons for the Claim Denial includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.

- The Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

- Notices will be provided in a culturally and linguistically appropriate manner.

How to Appeal a Claim Denial

All Claim Denials are subject to at least one opportunity for a full and fair review. This review is called the "internal appeal."

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. The Board of Trustees reviews claims denied by the Administrative Manager and Blue Cross Blue Shield of Michigan. Insured claims and Delta Dental claims are not subject to review by the Board of Trustees and are subject to the claims and appeals process of the insurer for insured benefits and Delta Dental for Dental Benefits.

In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review of your claims will take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination.

If you ask us to, the Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Claim Denial, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.

- The date(s) of health care service(s).

- The provider's name.

- The reason you believe the claim should be paid.

- Any documentation or other written information to support your request for claim payment.

Claims Unrelated to Denial of Payment for Specific Benefits

You may appeal any denial of a claim within 60 days of a denial by submitting a written request for review to the Plan Administrator.

What Happens when You Appeal Loss of Time and Group Health Plan Claim Denials

For purposes of this appeal procedure, "group health plan" means the following benefits:

- Basic Benefits;
- Miscellaneous Benefits;
- Prescription Medicine Benefits;
- Individual HRA Benefits;
- Dental Benefits; and
- Certain benefits under the Employee Assistance Program.

The following appeals procedure will apply to claims made for benefits under a group health plan or for loss of time benefits.

You may appeal any Claim Denial within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator (the Board of Trustees).

The review of your appeal will involve a "fresh look" by the Board of Trustees, and the Board of Trustees will not give any extra weight to the initial claim decision. If any Trustees were involved in the initial Claim Denial, they will not participate in the review of your appeal. If all Trustees were involved in your initial Claim Denial, you will be referred immediately to an independent review organization that handles the external appeal procedure. See "External Review Process" later in this section.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Claim Denial that is the subject of the appeal, nor the subordinate of any such individual.

If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Board of Trustees may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

In the case of a claim under a group health plan involving urgent care, you are entitled to an expedited review process pursuant to which—

- You may submit a request for an expedited appeal of a Claim Denial orally or in writing; and
- All necessary information, including the Plan's benefit determination on review, shall be transmitted from the Plan to you by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended as permitted below due to your failure to submit information necessary to decide an appeal, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

Timing of Internal Appeal Decision

Except as provided below for Pre-Service and Urgent Care claim appeals, the Board of Trustees will make a benefit determination no later than the date of the meeting of the Board of Trustees that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In that case, a benefit determination may be made by no later than the date of the second meeting of the Board of Trustees following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees will provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made,

prior to the commencement of the extension. The Board of Trustees will notify you of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Notice of Appeals Determinations

Pre-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), you will be notified by the Plan Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for appeal of a denied claim.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals That Require Immediate Action" below.

Please note that the Board of Trustees' decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is right for you is between you and your doctor.

Urgent Care Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Board of Trustees as soon as possible. The Board of Trustees will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

- If the Claim Denial involves a medical condition for which the time frame for completion of an Internal Appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may file a request with the Board of Trustees for an "expedited external review."

The Board of Trustees has the exclusive right to interpret and administer the provisions of the Plan. The Board of Trustees' decisions are conclusive and binding. The Board of Trustees has final claims adjudication authority under the Plan.

Manner of Notification of Appeal Decision

The Board of Trustees will provide a Member with written or electronic notification of a Plan's benefit appeal decision. If the appeal is denied (an "Internal Appeal Denial"), the notification will set forth, in a manner calculated to be understood by you:

(a) The specific reason or reasons for the Internal Appeal Denial;

(b) Reference to the specific Plan provisions on which the Internal Appeal Denial is based;

(c) A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Member's right to obtain the information about such procedures;

(e) A statement of the Member's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended;

(f) In the case of a group health plan or a plan providing disability benefits—

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Internal Appeal Denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the final Claim Denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

- If the Internal Appeal Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(g) A statement indicating that you will be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

(h) In addition:

- The Plan must ensure that any notice of Internal Appeal Denial includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable).

- You will be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice will contain a statement to that effect.

- The Plan must ensure that the reason or reasons for the Internal Appeal Denial includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim.

- The Plan must provide a description of External Review processes, including information regarding how to initiate an appeal.

- Notices will be provided in a culturally and linguistically appropriate manner.

Voluntary Extensions

As described above, the Board of Trustees must decide your claim and/or appeal within certain time frames, and the Board of Trustees may extend those time frames in its discretion in certain circumstances. In addition, the Board of Trustees may request that you voluntarily agree to allow the Board of Trustees additional time extensions. You may allow or deny these additional "voluntary" extensions in your discretion.

External Review Procedures

With respect to Basic Benefits, Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA Benefits and Dental Benefits:

- You may be entitled to request an external review of an internal appeal claim denial by the Plan (an "External Review"); and

- If your situation is urgent, you may be entitled to an Expedited External Review of a claim denial by the Plan (an "Expedited External Review").

External Review Process

This External Review Process follows interim guidance from the federal agencies that are responsible for Health Care Reform, and apply effective January 1, 2014 until replaced by future guidance.

External Review is not available for all Internal Appeal Denials. For example, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a plan is not eligible for External Review. In addition, the External Review Process is suspended until further notice except for claims relating to rescissions and/or medical judgment. The Plan Administrator further reserves the right to exclude from External Review additional types of claim denial as may be permitted under Health Care Reform and any related guidance issued from the federal agencies that are responsible for implementation of Health Care Reform.

External Review

"External Review" is External Review that is not considered expedited (as described below and referred to as "Expedited Internal Review").

The Plan Administrator (the Board of Trustees) will allow you to file a request for an External Review with the Plan Administrator if the request is filed within four months after the date of receipt of a notice of a claim denial. If there is no corresponding date four months after the date of receipt of that notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days following the date of receipt of the External Review request, the Administrative Manager will complete a preliminary review of the request to determine whether you meet all of the following requirements for External Review:

(a) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(b) The Internal Appeal Denial does not relate to the your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

(c) The internal Appeal Denial relates to rescission of coverage or medical judgment or "medical necessity;"

(d) You have exhausted the Plan's internal appeals process unless you are not required to exhaust the internal appeals process under applicable regulations; and

(e) You have provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Administrative Manager will issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Plan will allow a Participant to perfect the request for External Review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The Administrative Manager will refer requests that are eligible for External Review to Blue Cross Blue Shield of Michigan, which will assign an independent review organization ("IRO") that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, Blue Cross Blue Shield will take action against bias and to ensure independence. Accordingly, Blue Cross Blue Shield of Michigan will contract with IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other

independent, unbiased methods for selection of IROs, such as random selection). Blue Cross Blue Shield of Michigan will contract with at least three IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO will provide the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(c) Within five business days after the date of assignment of the IRO, the IRO Referrer will provide to the assigned IRO the documents and any information considered in denying the Claim or Internal Appeal Denial. Failure by the IRO Referrer to timely provide the documents and information must not delay the conduct of the External Review. If the IRO Referrer fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Claim Denial. Within one business day after making the decision, the IRO must notify you and the IRO Referrer.

(d) Upon receipt of any information submitted by you, the assigned IRO will within one business day forward the information to the Administrative Manager. Upon receipt of any such information, the Administrative Manager will forward it to the Board of Trustees to reconsider the Claim Denial that is the subject of the External Review. Reconsideration by the Board of Trustees must not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Board of Trustees decides, upon completion of its reconsideration, to reverse the Claim Denial and provide coverage or payment. Within one business day after making such a decision, the Board of Trustees must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Board of Trustees.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim “de novo” (that is, take a “fresh look” at the claim) and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you or your treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan or the Plan Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO must provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of final External Review decision to you and the Plan.

(g) The assigned IRO's decision notice will contain:

- A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

- The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you; and

- A statement that judicial review may be available to you

(h) After a final External Review decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final External Review decision reversing the Claim Denial, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim.

Expedited External Review

The Plan must allow you to make a request for an Expedited External Review with the Plan at the time you receive:

(a) An Internal Appeal Denial that involves a medical condition of yours for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(b) An Internal Appeal Denial, if you have a medical condition where the time frame for completion of a Standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Internal Appeal Denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for Expedited External Review, the IRO Referrer will determine whether the request meets the reviewability requirements set forth Above for Standard External Review. The IRO Referrer will immediately send a notice that meets the requirements set forth above for Standard External Review to you of its eligibility determination.

Upon a determination that a request is eligible for External Review following the preliminary review, the IRO Referrer will assign an IRO pursuant to the requirements set forth above for Standard External Review. The IRO Referrer will provide or transmit all necessary documents and information considered in making the Claim Denial to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of final External Review decision. The Plan's contract with the assigned IRO must require the IRO to provide notice of the final External Review decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the IRO's notice of decision is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Plan.

Questions About Your Claims and Appeal Rights

For questions about your rights, these claims procedures, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

SECTION 22

COORDINATION OF BENEFITS AND SUBROGATION

This section includes helpful information about these important topics:

- Coordination of Benefits.
- Subrogation.

Coordination of Benefits (COB)

What does Coordination of Benefits mean?

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, but without duplicate payments. Your Plan requires that your Benefit payments be coordinated with benefit payments from another group plan under which you are covered for services that may be payable under both plans so that payment responsibilities will be fair.

COB makes sure that the level of payment when added to the benefits payable under another group plan, will cover up to 100% of the eligible expenses as determined between the carriers, at least to the extent the two plans together will provide 100% of coverage. COB also makes sure that the combined payments of all coverage will not exceed the actual cost approved for your care.

How COB Works

How does COB work?

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

- The carrier that pays first is your **primary plan**. This plan must provide you with the maximum benefits available to you under the plan.
- The carrier that pays second is your **secondary plan**. This plan provides payments toward the balance of the cost of covered services-up to the total allowable amount determined by the carriers.

Guidelines to Determine Primary and Secondary Plans

- If a group health plan does not have a Coordination of Benefits provision, that plan is primary.
- The plan that covers the Patient as the employee is primary and pays before a plan that covers the Patient as a Spouse or Child.
- If a Child is covered under both the mother's and father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.
- For Children of divorced or separated parents, benefits are determined in the following order unless a court order places financial responsibility on one parent: First, the plan of the custodial parent and second, the plan of noncustodial parent.
- If the primary plan cannot be determined by using the guidelines above, then the plan that has been covering the Child the longest is primary.

- The above guidelines apply except for certain situations in which an employee has retired or been laid off. Then special rules apply. Call the Administrative Manager if this applies to you.

Filing Blue Cross Blue Shield COB Claims

Always submit claims to your primary carrier first. When you submit claims to Blue Cross Blue Shield for reimbursement of the balance, please follow these steps:

- Obtain an Explanation of Benefits (EOB) from the primary carrier.
- Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service, and submit this.
- If you made any payments for the service, provide a copy of the receipt you received from the provider.
- 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 identification number (PIN). If the provider is located outside of Michigan, include the provider's tax ID number.

Send these items to:

Blue Cross Blue Shield
600 Lafayette East
Detroit, Michigan 48226
Attention: COB Department # B571

Please make copies of all forms and receipts for your own files before you submit them, because Blue Cross Blue Shield cannot return the originals to you.

Filing Fund COB Claims for Miscellaneous Benefits

What if the claim is for Miscellaneous Benefits?

When a Participant, Spouse or Child is covered under more than one plan for a service that under this Plan is not a Basic Benefit, but instead a Miscellaneous Benefit paid directly by the Fund, a costly duplication of benefits can result. Coordination of Benefits (COB) assures that all medical coverage you have (including, for example, policies for athletic injuries and cancer) will be accessed. After these policies have paid for your medical services according to their limits, the Fund will pay the remaining charges, subject to the limits set forth in this SPD.

Claims should be mailed to the address of the Administrative Manager at the end of this SPD.

Updating COB Information - Your Responsibility

What is my responsibility regarding COB claims?

It is important that you keep your COB records updated. For Blue Cross Blue Shield or the Fund to properly determine whether other plans may be involved in the payment of your medical expenses, it is necessary for the Participant to complete and submit a yearly COB questionnaire. If there are any changes in coverage information for your Spouse or Children, notify Blue Cross Blue Shield or the Administrative Manager's Office immediately. Please help Blue Cross Blue Shield or the Fund serve you better by responding to requests for COB information.

Outdated information can affect payment of your claims as follows:

If the information you provided on your initial COB questionnaire is over one year old and you submit a claim for benefits, your claim will be held up temporarily. The Administrative Manager's Office will send you a letter requesting information about other health care carriers. When you respond, the Administrative Managers Office will update your record. Your claim will then be processed according to the COB rules described above.

Subrogation

What is subrogation?

In certain cases, a third party (another person, insurance company or organization) may be legally obligated to make payment(s) to you relating to an injury or illness for which the Fund would otherwise pay the related costs and expenses. When this happens, the Fund is not required to pay for anything that the third party would otherwise pay for. If the Fund does, anyway, it has all the rights that you would have in any partial or full recovery you eventually get from the third party (up to the amount that the Fund paid).

How does it work?

- The Fund may go ahead and make the payments it would make if there were no third party involved. It may require you to sign a Subrogation Agreement before it does this.

- You must attempt to pursue any claims again the third party, and do whatever is necessary to help the Fund pursue such claims.

- The Fund is entitled to any payment that you receive from the third party, up to the amount it has paid relating to the injury or illness. This is the case:

    - no matter what form the payment come in (ex. through a lawsuit, settlement or any other means),
    - even if you only ever get partial recovery (rather than full recovery) from the third party, and
    - no matter how the recovery is characterized (for example, whether described as relating to medical expenses or not).

- Until the Fund has received full reimbursement out of the payment(s) from the third party, it has a security interest in and/or lien against those payments.

- These provisions do not apply to payments you receive because of your having purchased additional insurance coverage in your own name.

Effect of Medicaid Coverage

What if I am covered by Medicaid?

Benefits under this Plan will be paid without regard to whether the Participant Spouse or Children are covered by Medicaid, and payment of benefits will be made in accordance with any assignment of rights as required by a state Medicaid program and benefits will be paid in accordance with any state law under which the state has acquired the rights to payment with respect to a Participant, Spouse or Child entitled to coverage under the Plan.

SECTION 23

DELTA DENTAL PLAN OF MICHIGAN COVERAGE

You have available dental care coverage administered by Delta Dental. Your plan is called Delta Dental. In addition to this description, a Summary of Dental Plan Benefits shall be provided to you directly by Delta Dental.

Delta Dental pays 50% of the Approved Amount of most basic dental services, including diagnostic and preventive services and emergency palliative treatment, and prosthodontic services, up to a cumulative amount of $800 per covered person per calendar year (this is 50% of $1,600 of Approved Amount). This annual limit does not apply to pediatric dental services (services for Children through the age of 18). However, pediatric dental services are subject to the 50% co-payment requirement. A specification of just what is covered and not covered is set forth below in the subsection entitled **Delta Dental USA Plan Benefits, Exclusions and Limitations**.

Eligibility

Who is eligible for the Delta Dental coverage?

The eligibility rules for Delta Dental coverage are exactly the same as for your other health care coverage, as it is part of the same plan. If you, your Spouse and your Children are eligible for the medical and hospital coverage, you are eligible for Delta Dental coverage.

Contracting Dentists

Must I use a dentist who contracts with Delta Dental?

No, but as with medical coverage, it is certainly easier and more efficient if you do so. Dentists who contract with Delta Dental are referred to as Contracting Dentists. You will find that most dentists in Michigan do contract directly with Delta Dental. See the following paragraphs with regard to how claim processing and reimbursement differs.

Method of Payment

Does Delta Dental pay the dentist directly, or reimburse me?

It depends on whether you use a Contracting Dentist or not. If you use a Contracting Dentist, Delta Dental pays the dentist directly based on the dentist's contract, you receive a statement of the amount paid, and you are obligated for the balance. If you do not use a Contracting Dentist, then your dentist needs to submit your claim to Delta Dental, and Delta Dental will reimburse you the approved amount. (See below.) In this case, you are obligated to pay your dentist the full amount of the dentist's fees, which is usually expected at the time the services are rendered. You need to be sure your dentist submits your claim.

If your dentist is not familiar with Delta Dental, has any questions or needs a claim form, have him or her contact Delta Dental by writing to Delta Dental Plan of Michigan, Inc., P. 0. Box 30416, Lansing, Michigan 48909-7916 or by calling 517-349- 7781 or its toll-free number, 1-800-462-7283.

Claims, adjustment requests and completed information requests should be mailed to Delta Dental at the following address: Delta Dental Plan of Michigan, Inc., P. 0. Box 9085, Farmington Hills, Michigan 48333-9085.

Amount of Coverage

How much of my dentist's fees will Delta Dental pay?

For Contracting Dentists, Delta Dental will pay 50% of the amount established by the Delta Dental contract as the fee for the particular services rendered. For dentists who are not under the Delta Dental contract, Delta Dental pays one-half of the fee Delta Dental determines is usual or customary, which means within the range of usual fees charged by dentists of similar training and experience for the same service within the same specific and limited geographic area; and the fee must also be reasonable considering the special circumstances of the particular case. The fee that Delta Dental determines is usual or customary, toward which it pays 50%, may be less than the fee charged you by a non-contracting dentist.

Coverage Provisions

What dental work is covered and what is not covered?

Please see the pages at the end of this explanation section entitled **Delta Dental Plan Benefits, Exclusions and Limitations** for specification of the procedures that are covered, what procedures are not covered, and what costs are paid by Delta Dental. Delta Dental covers what are referred to as Class 1 and Class 2 Benefits.

Arranging for Dental Work

How do I arrange for dental work that is to be covered by Delta Dental?

Make an appointment with the dentist of your choice and tell your dentist if you are covered under Delta Dental. Claim forms are provided to each dental office in Michigan for your convenience.

You or a member of the dental office staff must fill in the information portion of the claim form with the following:

- The Participant's full name and address.
- The Participant's social security number.
- The name and date of birth of the person receiving the dental care.
- The group name and number.

If your dentist is not located in Michigan or if your dentist cannot provide you with a claim form, you or your dentist can get a claim form from Delta Dental, as described above. Although your dentist is supposed to send the claim form in for you, you need to make sure this is done.

Predetermination

Do I have to get a pre-approval to assure proposed dental work is going to be covered by Delta Dental?

It is highly advisable for you to be pre-approved for dental work if the cost is to exceed $200. Delta Dental has a procedure for quick review of proposed work, and it is the only way you can be assured that coverage will be applicable. This procedure is called Predetermination.

After a routine oral examination, your dentist will list any necessary treatment on your claim form. If the cost of these services is less than the specified Predetermination amount of $200 or is limited to emergency care, Predetermination is not necessary.

Delta Dental strongly recommends that you have your dentist forward your treatment plan (claim form) to Delta Dental for Predetermination before he or she performs any services where the total charges will exceed the specified Predetermination amount. This Predetermination procedure will let you and your dentist know what services may be covered, what Delta Dental may pay under the terms of your Plan and what you may have to pay. Because this Predetermination procedure requires a minimal amount of time, it normally will not interfere with scheduling your appointments. You and your dentist should review your Predetermined claim before your dentist proceeds with treatment.

Disputes, Appeal and Review

What if I wish to question a decision concerning payment?

If your question concerns eligibility, call the Administrative Manager. If your question concerns payment for a particular dental service, proceed through Delta Dental's disputed claims procedure as follows.

Before following Delta Dental's disputed claims procedure, you or your dentist should resubmit the claim as an inquiry to confirm that Delta Dental's determination was correct and that all supporting documentation was submitted. Please note that contractual exclusions and limitations cannot be altered. If the claim is still denied, you can follow this disputed claims procedure.

Your disputed claim for benefits must be written and mailed by certified mail, return receipt requested, to the Dental Director, Delta Dental Plan of Michigan, Inc., P. 0. Box 30416, Lansing, Michigan 48909-7916.

Your written statement must indicate the Participant's full name and address, the Participant's social security number, and specific basis for your claim and any additional materials you wish to present. The Dental Director or designee will promptly review your statement and, if the claim is wholly or partially denied, may furnish you with a notice of the decision within 90 days of receiving the statement. The written notice will set forth:

- The specific reason or reasons for denial.
- The specific reference to the pertinent Plan provisions on which the denial is based.
- If applicable, a description of any further material or information necessary for you to provide and an explanation of why the material or information is necessary.
- A copy of the disputed claims appeal procedure.

If you do not receive notice within the 90-day period, the claim is considered denied and you can proceed to the disputed claims appeal procedure.

What if I am still not satisfied after going through the disputed claim procedure?

If you are still not satisfied, then you may file an appeal of your claim. After following the disputed claims procedure, you or your authorized representative may appeal to the Administrative Committee of Delta Dental (Administrative Committee) by filing a written request for review before the final appeal date set forth in the Dental Director's notice denying the disputed claim, or, if no date is given, within 150 days of submitting the initial written statement under the disputed claims procedure. Your written request must state specifically the reasons for requesting a review and why you believe the Dental Director's decision was incorrect. You or your authorized representative may review the plan and pertinent documents.

If you want a hearing, make your request to the Administrative Committee. The Administrative Committee, in its sole discretion, may, but is not required to, convene a hearing to consider matters raised in the written request. If the hearing is granted, you are entitled, at your own expense, to be represented by legal counsel, to request that a court reporter transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine the witnesses.

If no hearing is held, the Administrative Committee will render its decision not later than 60 days after receiving the written request for review. If a hearing is held, a decision will be rendered as soon as possible, but not later than 120 days after receiving your written request for review. The Administrative Committee's decision will be in writing and will include specific reasons for the decision, with specific references to pertinent Plan provisions on which the decision is based.

External Review Process

If your Administrative Committee appeal is denied, you may have the right to obtain external review of that decision. See "External Review Procedure" in Section 21.

Termination of Coverage

Can my Delta Dental coverage be terminated?

Your coverage, as with all aspects of the Plan, may be terminated if the Trustees eliminate or change the Plan, or if you lose eligibility for the Plan. Your coverage will terminate on the last day of the month in which either of these situations occurs. If the plan terminates, you will become responsible for payment of your dental expenses.

Coordination of Benefits, COBRA

Do Coordination of Benefits, Subrogation and COBRA all apply to the Delta Dental program?

Yes, all of those apply as set forth in the Plan.

What if my Spouse is covered by another dental plan?

Using both plans, you may be entitled to coverage for as much as (but not more than) 100% of the charges for covered dental services. It is important that you inform your dentist of any dual coverage so that the proper claim filing procedures are followed.

Miscellaneous Benefits Applicable

May I use any remaining Miscellaneous Benefits under the Plan to cover either the percentage of my dental bills not paid by Delta Dental or for services not covered by Delta Dental?

Yes, that is what the Miscellaneous Benefits are for. For services provided by a service provider that does not accept VISA, you must submit the balance of the claim to the Administrative Manager for reimbursement. You must also submit the Delta Dental EOB (Explanation of Benefits) with your claim.

Delta Dental Plan Benefits, Exclusions and Limitations

Class 1 Benefits that are covered:

- **Diagnostic and Preventive Services.** Services and procedures to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Such services might include examinations, prophylaxes and topical applications of fluoride.

- **Emergency Palliative Treatment.** Nonspecific treatment employed by dentists on an emergency basis to temporarily relieve pain.

- **Radiographs.** X-rays, as required or in conjunction with the diagnosis of a specific condition.

- **Oral Surgery Services.** Extractions and other surgical dental procedures, including preoperative and postoperative care.

- **Endodontic Services.** Procedures for the treatment of teeth with diseased or damaged nerves (for example, root canals).

- **Periodontic Services.** Procedures for the treatment of diseases of the gums and supporting structures of the teeth.

- **Restorative Services.** Services to rebuild, repair or reform natural tooth structure when necessary due to disease or injury. Restorative services include, but are not limited to, those listed below:

    - Minor restorative services such as amalgam and resin restorations and relines and repairs to prosthetic appliances.
    - Major restorative services such as jackets on anterior teeth and cast restorations when the teeth cannot be restored with another filling material.

Class 2 Benefits that are covered:

Prosthodontic Services. Services and appliances, such as bridges, partial denture and complete dentures that replace missing natural teeth.

Exclusions

No benefits will be provided for the following. You will be responsible for the charges for these services:

- Services for injuries or conditions compensable under Workers' Compensation or Employer's Liability laws; or benefits or services that are available from any federal or state government agency, from any municipality, county or other political subdivision or community agency, or from any foundation or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX Social Security Act, that is, Medicaid.

- Services that are determined by Delta Dental to be rendered to correct congenital malformations, cosmetic surgery or dentistry for cosmetic reasons.

- Services or appliances, including, but not limited to, prosthodontics (including crowns and bridges), started before an individual became eligible under this Plan.

- Prescription drugs, laboratory tests and/or examinations, premedications and/or relative analgesia; charges for hospitalization; general anesthesia and/or intravenous sedation for restorative dentistry; general anesthesia and/or intravenous sedation for surgical procedures, unless it is a medical necessity; preventive control programs, including home care items; and charges for failure to keep a scheduled visit with the dentist.

- Replacement repair, relines or adjustments of occlusal guards.

- Charges for completion of forms. These charges are not to be made by a Contracting Dentist to a person covered by Delta Dental.

- Sealants.

- Orthodontic services or supplies.

- Lost, missing or stolen appliances of any type and replacement or repair of orthodontic appliances.

- Services that are not necessary and/or customary as determined by the standards of generally accepted dental practice, for which no valid dental need can be demonstrated, that are specialized techniques or that are Experimental or Investigative in nature.

- Services that are not within the classes of Dental Benefits defined in the Plan.

- Appliances, surgical procedures and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion or erosion; for correcting congenital or developmental malformations; for aesthetic purposes; or for implantology techniques.

- Treatment by someone other than a dentist, except for the scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist under the supervision and guidance of a dentist in accordance with generally accepted dental standards.

- Those services and benefits excluded by the rules and regulations of Delta Dental, including the processing policies, which may change periodically.

- Services or supplies for which no charge is made, for which the Patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage.

- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

- Services that are covered under a hospital, surgical/medical or prescription drug program.

- Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

Limitations

The benefits provided by Delta Dental for the following services are limited as follows. For the purpose of this Plan, all time limitations are to be measured from the date on which those services were last supplied under any Delta Dental plan.

- Benefits for prophylaxes and oral exams are payable twice in any period of 12 consecutive months.

- Benefits for bitewing X-rays are payable once in any period of 12 consecutive months. Benefits for full mouth X- rays (which include bitewing X-rays) are payable once in any five-year period. A panographic X-ray (including bitewings) is considered a full mouth X-ray and is paid as such.

- Benefits for cast restorations, including jackets, crowns, onlays and associated procedures such as cores and post substructures, on the same tooth are payable once in any five-year period.

- Benefits for porcelain, porcelain substrate and cast restorations are not payable for eligible Children under 12 years of age.

- Optional treatment: In all cases in which the Participant, Spouse or Child selects a more expensive service than is customarily provided or for which Delta Dental does not believe a valid dental need is shown, Delta Dental will pay only the applicable percentage of the fee for the service, if any, that is customarily provided.

- For example, if a tooth can be satisfactorily restored with amalgam and you choose to have the tooth restored with a more costly material, the plan will pay only the applicable amount that it would have paid to restore the tooth with amalgam. You are responsible for the difference in cost.

- Benefits for root planing are payable once in any two-year period. Benefits for periodontal surgery, including sub-gingival curettage, are payable once in any three-year period.

- Prosthodontic (Class 2) Benefit limitations:

  - Benefits for one complete upper and one complete lower denture are payable once in any five-year period for any individual.
  - Benefits for a partial denture, fixed bridge or removable bridge for any individual are payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
  - Benefits for fixed bridges and removable cast partials are not payable for people under 16 years of age.

- Benefits for topically applied fluorides are payable for Children until their 19th birthday.

- Our obligation for payment of benefits ends on the last day of the month in which an individual becomes ineligible for benefits.

- When services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each dentist.

- Care terminated due to death of a Participant, Spouse or Child will be paid in full, to the limit of the Plan's liability, for the services completed or in progress.

- The maximum benefit payable in any one contract year or any portion thereof will be limited to $800 per person (age 19 or older) total on Class 1 and Class 2 Benefits.

- Processing policies, which may change periodically, may limit treatment.

Contacting Delta Dental

You may access Delta Dental's website at deltadentalmi.com in order to:

- Print membership cards.

- Print an EOB.

- Check the status of a claim.

- To obtain a list of Participating Provider dentists.

SECTION 24

MAGELLAN HRSC INC. - EMPLOYEE ASSISTANCE PROGRAM (EAP)

We have arranged a further health benefit service to assist you and anyone living in your family household in dealing with emotional, marital, substance use disorder, financial, legal, family and work difficulties that may be encountered. It is recognized that daily living concerns/issues may, without professional assistance, sometimes lead to serious problems that can even involve substance use disorder or mental health conditions.

The Plan has contracted with Magellan HRSC, Inc. (Magellan) to provide to you as a Participant, or a member of your household, telephone contact with specially trained personnel to talk to you about your difficulty, and if necessary following a telephone contact, give you a referral to a qualified professional resource to help you with the particular situation. This program is referred to as an Employee Assistance Program (EAP).

Eligibility

Who is eligible for the Magellan coverage?

The assistance that the Magellan EAP Program provides is somewhat different and more comprehensive than your medical/hospital benefits, and is focused on members of your immediate household. Therefore, you as a Participant and anyone living in your household are eligible for the EAP Program.

Kind of Help

Specifically, what kind of help do I get from this EAP Program, and how do I get it?

You or a member of your family household may call by telephone a Magellan specialist at 1-800-724-PIPE (7473) to discuss your particular problem. This specialist will review your situation with you, make a clinical assessment of the help you need, if you need help, and will refer you to a trained professional clinician who is part of the Magellan network, or will refer you to an appropriate community-based resource. You may visit this clinician or go to the community-based resource personally and work with them to help resolve your difficulties.

Frequency of Use

How often may I use this telephone and personal consultation?

You and each household member may call by telephone any number of times 24 hours a day, 7 days a week. Personal visits through Magellan Health Services to a professional clinician who is part of their network are limited to **five times per calendar year per covered person in your household**. One person cannot use the allocation of another person in the household coverage unit. Visits to a community-based resource are not limited, even if referred by Magellan, but read the next paragraph about possible charges from that agency.

Cost

Is there a cost to me for this telephone and personal consultation?

No, not for any telephone consultation with the Magellan representative, or up to five personal visits per covered person with a referred professional clinician per calendar year. If you obtain other professional help beyond these five visits, even through a reference from Magellan, other than to a free community-based resource, you will need to check whether or not it is covered by the other coverages of the Plan, because otherwise you will be responsible for the payment. Please recognize that all community-based resources are not free, and even if you go there as a result of a Magellan referral, their charges are not covered in this EAP Program. The five free visits per year covered by the EAP Program are to clinicians who are part of the Magellan network.

Privacy

Since this subject might involve behavior that is very personal and private, or even substance use disorder, can we be assured of confidentiality if we call a Magellan representative?

Yes. Our contract with Magellan specifically provides for the confidential relationship of providing a health benefit.

Situations Covered

What kind of situation is included in this Benefit?

You, your Spouse, or Children may call concerning any emotional or behavioral problem being experienced by you or a member of your household. Representative situations that would be covered include:

Alcohol/Drug

Alcohol Dependency/Substance Use Disorder
Drug Dependency/Substance Use Disorder
Prescription Drug Use Disorder
Family Alcohol or Drug Co-Dependency

Family Relationship Concerns

Domestic Violence
Child Abuse or Neglect
Separation or Divorce Adjustment
Single Parenting
Step-Parenting
Teenage Adjustment
Parent-Child Relationships
Value of Role Conflicts

Behavioral Concerns

Gambling
Phobias
Smoking
Eating
Lying
Spending

Personal Emotional Concerns

Anxiety Reactions
Stress
Anger Management
Depression
Suicidal Thoughts
Chronic or Terminal Illness
Sexual Concerns
Post Traumatic Stress Issues
Guilt
Fear or Insecurity
Loss or Grief
Legal Issues

Occupational Adjustment

Job Adjustment Concerns
Retirement
Career Changes
Promotion
Relocation

Work and Family Life Issues

Planning and Outplacement
Impact of New Technology
Communication/Group Dynamics
Team Building/Managing Change
Human Resources
Policy/Planning
Crisis/Grief Intervention
Elder Care Planning
Child Care Planning

What if I have questions regarding the specific services offered?

Please call the toll free line, 1-800-724-PIPE (7473) and ask the Magellan representative.

Can my Magellan coverage be terminated?

Your coverage, as with all aspects of the Plan, may be terminated if the Trustees eliminate or change the Plan, or if you lose eligibility for the Plan. Your coverage will terminate the last day of the month in which either of these situations occur.

SECTION 25

DEFINITIONS

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

Actively At Work - A Member who is not disabled, who is not retired, and who is working under the jurisdiction of UA Local 190 Plumbers/ Pipefitters/ Service Technicians/ Gas Distribution.

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

Acute Care Facility - A facility that 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 Use Disorder treatment.

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

Administrator - See definition for Plan Administrator.

Administrative Manager - The person or organization appointed by the Board of Trustees to administer day-to-day activities of the Plan and Trust.

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

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.

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

Approved Amount - The provider's billed charge for the covered service, or the maximum payment level allowed by the insurance or other company administering the benefits, whichever is lower.

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.

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 or an affiliate of Blue Cross Blue Shield.

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

Assigned Claim – A claim for services provided by a Medicare participating provider or another provider that has accepted assignment on a claim. These providers have agreed to accept the Medicare approved amount as full payment.

Attending Physician - The physician in charge of a case who exercises overall responsibility for the patient's care.

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

Autism Evaluation Center - An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. The autism evaluation center must be approved by BCBSM to:

- Evaluate and **diagnose** the member as having one of the covered autism spectrum disorders and
- Recommend an initial high-level treatment plan for members with autism spectrum disorders.

Autism Spectrum Disorders - Autism spectrum disorders include Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

Basic Benefits - The benefits administered by Blue Cross Blue Shield pursuant to its contract with the Plan.

BCBSM – Blue Cross Blue Shield of Michigan.

Behavioral Health Treatment - Evidence-based counseling and treatment programs, including applied behavior analysis, which meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

Beneficiary - The person you have designated to receive the resources of the Fund after your death, or any person designated by a covered person to receive that covered person's benefit.

Benefit - Payment for health care services available in accordance with the terms of your health care coverage.

BlueCard Participating Provider - A provider who participates with the Host Plan.

Blue Cross Blue Shield Association - An association of independent Blue Cross 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 - 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.

Board Certified Behavior Analyst - An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.

Note: Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

Board of Trustees - The Trustees elected or appointed by labor and management to adopt and administer the Plan and Trust.

Carrier - An insurance company that provides a health care plan for its members.

Certified Registered Nurse Anesthetist - A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan, and
- Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing, and
- Meets Blue Cross Blue Shield qualification standards, and
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed

Child – Effective January 1, 2014, your biological or adopted child, or the child of the person to whom you are legally married during the period you are legally married, up to age 26. Prior to January 1, 2014, only children from the age of 19 through 26 who were not eligible for other employment-based coverage, other than through a parent met the definition of "child." Effective June 1, 2012, an adopted child includes your legally adopted child or a child who is lawfully placed with you for legal adoption by you.

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

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

COBRA (Consolidated Omnibus Reconciliation Act of 1985) - The continuation of health coverage upon satisfying a qualifying event within the meaning of Section 4980B of the Code.

Code - The Internal Revenue Code of 1986, as amended from time to time.

Co-insurance- Under Standard Coverage, the designated percentage of the Approved Amount you are required to pay for Covered Services.

Contracting Dentist - A dentist who has agreed to participate with Delta Dental Plan of Michigan and to accept its rules and fees.

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

Co-payment – Under Enhanced Coverage, the designated portion of the Approved Amount you are required to pay for Covered Services, either as a percentage or flat dollar amount. Under Standard Coverage, the designated flat dollar amount of the Approved Amount you are required to pay for Covered Services.

Covered Person - A Participant, Spouse or Child currently entitled to the benefits of the Plan.

Covered Services - Services, treatments or supplies identified as payable by the Plan. Covered services must be a medical necessity 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 medical services before the Plan begins to pay.

Designated Facility - To be a covered benefit, human organ transplants must take place in a "Blue Cross Blue Shield-designated" facility. A designated facility is one that Blue Cross Blue Shield determines to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to you and your physician upon request.

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.

Early Retiree - A Participant who retires prior to age 60.

Employer - An employer bound by the collective bargaining agreement with Local 190 United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada (also referred to as "Local 190"). With respect to employees of Local 190, Local 190 is considered an "Employer." Certain Fringe Benefit Funds established pursuant to collective bargaining agreements with Local 190 may also be considered "Employers" with respect to their employees.

ERISA - The Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulations issued pursuant to ERISA.

ESRD - End Stage Renal Disease; permanent kidney failure which requires a regular course of dialysis or a kidney transplant.

Evaluation - An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

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 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 use disorder treatment rehabilitation, skilled nursing care or physical therapy.

Fund - The Trust providing all benefits under the Plan, jointly established and administered by the Trustees.

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

Hospital - A facility that provides inpatient diagnostic 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.

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

Independent Physical Therapist - A licensed physical therapist who 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.

Line Therapy - Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

Lobar Lung - A portion of a lung from a cadaver or living donor.

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

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 or **Medically Necessary** - A service must be medically necessary in order to be payable by your health care coverage. Medical necessity definitions for hospital services and medical services follow.

Medical necessity for **hospital services** requires that:

- The service is for 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.
- The services are not mainly for the convenience of the Participant or health care provider.
- Blue Cross Blue Shield does not generally regard the treatment as experimental or investigative.

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

- The 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 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 Participant or physician.

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

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

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

Medicare-Eligible Retiree – A retired Member who is age 65 or older.

Member - A person who is a member in good standing of Local 190, or is eligible for participation in the Plan under Plan provisions.

Miscellaneous Benefits - The benefits awarded directly by the Fund such as vision, uninsured medical expenses (excluding co-pays) and uninsured dental (including co-pays), as specifically provided in Section 10.

Non-Bargaining Unit Employee - An employee of an Employer who is neither a Member, nor employed in the capacity as an executive or officer of such Employer.

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

Participant - Any active or retired person who is or was employed by an Employer and who is covered by the Plan.

Participating Providers - Providers that have signed participation agreements with Blue Cross Blue Shield agreeing to accept the Blue Cross Blue Shield approved amount for covered services as payment in full on a per claim basis.

Patient - The Participant or eligible Spouse or Child who is awaiting or receiving medical care and treatment.

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).

Plan - The UA Local 190 Health and Welfare Plan and/or the UA Local 190 Individual HRA Plan, as amended or restated from time to time.

Plan Administrator - The person who is responsible for the performance of all reporting requirements and disclosure obligations as described in ERISA. The Plan Administrator is the Board of Trustees.

Plan Year - The twelve-month period beginning June 1 and ending on the subsequent May 31.

Presurgical Consultation – The second and third visits with a physician other than the physician who initially recommends surgery, who is a doctor of medicine, osteopathy, podiatry or an oral surgeon. The purpose of a visit after the initial visit is to confirm the necessity of surgery and determine the medical tolerance for the proposed surgery.

Prior Authorization Process - A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine month intervals or at other mutually agreed upon intervals after the onset of treatment.

Professional Provider - One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Fully licensed psychologist
- Clinical licensed master's social worker
- Oral surgeon
- Board certified behavior analyst
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

Prosthetic Device - An artificial appliance that:

- Replaces all or part of a body part, or

- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ.

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

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

Registered Provider - A participating or nonparticipating provider that is an in-network or out-of-network PPO provider that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

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

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

Skilled Nursing Facility - A facility that provides continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility must have a written agreement with Blue Cross Blue Shield to provide benefits under the Plan.

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.

Spouse - The person to whom you are currently legally married.

Substance Use Disorder - Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic wellbeing.
- Cause the person to lose self-control.
- Endanger the safety or welfare of others because of the substance's habitual influence on the person.
- Substance abuse is alcohol or drug abuse or dependence as classified in Categories 303.2 through 305.0 and 305.2 through 305.9 of the most current edition of "International Classification of Diseases."

Surviving Spouse - A widow or widower of a deceased Participant for the period that she or he remains unmarried.

Totally and Permanently Disabled Participant - A Participant who is no longer able to perform the duties of his or her job or occupation, anticipated to be a permanent condition, as described in the UA Local 190 Pension Plan.

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

Treatment Plan for Autism Disorders - A written, comprehensive, and individualized plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at three, six and/or nine months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

- The approved autism evaluation center will recommend an initial high-level treatment plan.
- The board certified behavior analyst will develop a detailed treatment plan specific to applied behavior analysis treatment.

Trust - The UA Local 190 Health and Welfare Trust and/or the UA Local 190 Individual HRA Trust, which are the depository of all Employer contributions and the source of all benefit payments.

Trust Fund - The trust funds providing all benefits under the Plans, jointly established and administered by the Trustees.

Trustees - The Trustees elected by labor and appointed by management to adopt and administer the Plan and Trust. Also known as the Board of Trustees or Joint Board of Trustees.

Unassigned Claim – A claim for a service for which the provider has not agreed to accept the Medicare approved amount as payment in full.

You and Your - used when referring to any person covered under this Plan.

BLUE CROSS BLUE SHIELD

When calling or visiting, please know your contract number from your Blue Cross Blue Shield ID card.

Statewide Customer Service Phone Numbers

Monday through Friday 8:30 a.m.-noon and 1:00 p.m.-5:00 p.m.

Blue Cross Blue Shield Customer
Service Center for
UA Local 190
Health and Welfare Fund (877) 790-2583

Hearing and Speech Impaired

Area Code 313 or 810 (313) 225-6903 or (313) 225-4028
Area Code 616 (616) 285-2114 or (800) 867-8980

These phone numbers are <u>not</u> for Medicare inquiries.

Special Servicing Numbers

Anti-Fraud Hotline (in Michigan) (800) 482-3787
Anti-Fraud Hotline (outside of Michigan) (313)225-8100

BlueHealthConnection (800) 775-2583

Address for Written Inquiries:

Major Groups Customer Service
Blue Cross Blue Shield
600 Lafayette East, Department #0204
Detroit, Michigan 48226

In addition, Blue Cross Blue Shield provides the following additional information regarding how to contact Blue Cross Blue Shield:

How to Reach Blue Cross Blue Shield

This section lists phone numbers and addresses to help you get information quickly. You may call Blue Cross Blue Shield or visit Blue Cross Blue Shield's centers.

To Call

Most of Blue Cross Blue Shield's customer service lines are open for calls between 8:30 a.m. and noon and from 1 p.m. to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call. (The contract number is usually the subscriber's nine-digit social security number.)

Area Code 248, 313, 586, 734, 810 or 947
Detroit..... (313) 225-8100
Southeast Michigan Toll-free ..... (800) 637-2227

Area Code 231, 269 or 616
West Michigan Toll-free..... (800) 972-9797

Area Code 517 or 989
Central Michigan Toll-free ..... (800) 258-8000

Area Code 906
Marquette ..... (906) 228-9112
Upper Peninsula Toll-free ..... (800) 562-7884

To Visit

Blue Cross Blue Shield customer service centers are located throughout Michigan. Check the following list to find the center nearest you. Unless stated otherwise, the centers are open from 8:30 a.m. until 5 p.m., Monday through Friday.

Alpena
135 W. Chisholm Street, Alpena 49707
On the main street in downtown Alpena

Detroit
500 East Lafayette Boulevard, Detroit 48226
Downtown, two blocks north of Jefferson at I-375
Open from 8:30 a.m. to 4:30 p.m.

Flint
4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids
86 Monroe Center, NW, Grand Rapids 49503
Open from 8:0 a.m. to 6 p.m.

Holland
259 Hoover Boulevard, Suite 180, Holland 49423
Near U.S. 31 and 8th Street

Jackson
2282 Springport Road, Suite H, Jackson 49212
In Springport Center, ½ mile west of U.S. 127
Open from 8:30 a.m. to noon and from 1 p.m. to 5 p.m.

Lansing
1405 Creyts Road, Lansing 48917
¼ mile south of I-496, Creyts Road exit
Open from 8:30 a.m. to 4:30 p.m.

Marquette
415 S. McClellan Avenue, Marquette 49855
Up on the hill

Mt. Pleasant
1620 South Mission, Mt. Pleasant 48858
In the Campus Court shopping mall
Open from 8:30 a.m. to 12:30 p.m. and from 1:30 p.m. to 5 p.m.

Muskegon
1034 E. Sternberg Road, Muskegon 49444
The Pointes Mall

Portage
2255 W. Centre Avenue, Portage 49024
1 mile east of Centre Avenue exit off Route 131 at Oakland Drive (next to Bank One)

Port Huron
1924 Pine Grove Avenue, Port Huron 48060
Behind Global Insurance

Saginaw
4300 Fashion Square Boulevard, Saginaw 48603
¼ mile south of the Fashion Square Mall

Traverse City
1769 S. Garfield Avenue, Traverse City 49686
Across from Cherryland Center

Utica
6100 Auburn Road, Utica 48317
Diagonally across from the AAA Building

Administrative Manager:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Famrs, Michigan 48025

1-888-390-PIPE (7473)

I:\CL\9802\HEALTH\1 SPD-Plan

UA LOCAL 190
HEALTH AND WELFARE PLAN

UA LOCAL 190
MEDICARE RETIREE HEALTH AND WELFARE PLAN

UA LOCAL 190
INDIVIDUAL HRA PLAN

SUMMARY PLAN DESCRIPTION

PROVISIONS IN EFFECT AS OF
JUNE 1, 2017

THE FOLLOWING HEALTH AND WELFARE BENEFITS ARE DESCRIBED IN THIS DOCUMENT:

Basic Benefits
(Medical and Hospital Coverage
as administered by
Blue Cross Blue Shield of Michigan)

Miscellaneous Benefits

Prescription Medicine Benefits

Individual Health Reimbursement Account

Life Insurance Death Benefit

Accidental Death and Dismemberment

Loss of Time Benefits

Dental Coverage
as administered by
Delta Dental Plan of Michigan, Inc.

Magellan HRSC, Inc.
Employee Assistance Program

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UA LOCAL 190
HEALTH AND WELFARE PLAN

UA LOCAL 190
MEDICARE RETIREE HEALTH AND WELFARE PLAN

UA LOCAL 190
INDIVIDUAL HRA PLAN

INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

(referred to as the "SPD")

TO THE MEMBERS AND COVERED SPOUSES AND CHILDREN OF UA LOCAL 190 PLUMBERS/ PIPEFITTERS/ SERVICE TECHNICIANS/ GAS DISTRIBUTION:

We, as Trustees of the UA Local 190 Health and Welfare Plan, the UA LOCAL 190 Medicare Retiree Health and Welfare Plan, and the UA LOCAL 190 Individual HRA Plan ("Plan"), are constantly seeking to provide you and your families with the best available health care, at the most competitive prices. In previous years it was determined that the same high level of care that has historically been furnished you could be continued, at less cost, by making use of the Blue Cross Blue Shield of Michigan ("Blue Cross Blue Shield") administration and negotiated payment structure. Participating in the Blue Cross Blue Shield network also provides you with a Blue Cross Blue Shield card, facilitating the delivery of service to you.

Attached to this Introduction is a Summary Plan Description (SPD) of the Plan, which sets forth in detail eligibility requirements, coverages with Blue Cross Blue Shield, and additional coverages that continue to be provided by the Fund directly or through other organizations.

As you read this material, please remember that the Plan incorporates certain Blue Cross Blue Shield certificates and riders which describe benefits in technical detail and which we cannot include here. We have consolidated the certificates, riders and other modifications relating to medical coverage into a detailed Benefit Schedule that is available from the Administrative Manager at no cost upon request. The attached summary together with the detailed Benefit Schedule constitute the official Plan document. You may receive a copy of the entire official plan document and the contracts, certificates, riders and plan modifications under which the Plan is operated, upon written request to the Administrative Manager.

This summary is designed to provide you with the necessary information in most cases to give you a clear answer. We do ask you to spend some time reading it, and review it carefully whenever you have a situation where you have a question. The information should be there. Of course, the staffs of Blue Cross Blue Shield and of our Administrative Manager are always ready to help you when you can't find the answer. We simply urge you to read the material carefully before you call, as this will increase your information as to the benefits you have and make the whole process easier and more productive for all of us. Definitions of terms used in the text are at the end of the SPD. Please flip back there to look at the definitions to make your reading more understandable. Capitalized words are usually defined terms.

Blue Cross Blue Shield has participating agreements with most doctors and all licensed Michigan hospitals. Under these agreements the medical provider agrees to accept the negotiated fees as payment in full. We encourage you to use these providers whenever you can, as it is easier for you - just present your Blue Cross Blue Shield card and it is taken care of. There is no follow-through paperwork for you. You are also covered, but with limitations, if you use providers who do not participate with Blue Cross Blue Shield, but you and the Administrative Manager must go through a claim payment process, and the provider may bill you for amounts that exceed the amount Blue Cross Blue Shield normally pays for the same services.

In Section 7 there is a chart outlining Basic Benefits paid by Blue Cross Blue Shield and those paid for by you as a Participant. Section 8 provides a summary and specification of your Basic Benefits furnished through Blue Cross Blue Shield and the co-payments and limits on numbers of visits for certain types of services. This section is divided into three basic sections: a section describing how we pay for hospital and facility services, a section describing how we pay for physician and other health care provider services, and a section explaining other benefits that fall outside of the usual Blue Cross Blue Shield coverage, such as preventive care services and hearing care. Section 9 consists of a listing of Medical Coverage General Conditions, Exclusions and Limitations.

The additional health benefits paid directly by the UA Local 190 Health and Welfare Trust ("Fund"), described as Miscellaneous Benefits, are in the SPD section 10, designated "Miscellaneous Benefits and Prescription Medicine Benefits." The Delta Dental Plan of Michigan, Inc. ("Delta Dental") Benefits and exclusions are in Section 23. The Employee Assistance Program is set forth in Section 24, and is sometimes referred to as "EAP." Further benefits paid for by the Fund are the basic Life Insurance Death Benefit (Section 12), the basic Accidental Death and Dismemberment Benefit (Section 13) and Loss of Time Benefits (Section 14). Effective December 1, 2015, an optional, supplemental group term Life Insurance Death Benefit and an optional, supplemental group Accidental Death and Dismemberment benefit are available to Members, Spouses and Children (with the requirement that Children be between 15 days and 26 years old and supported by the Member) at Members' expense. Effective December 1, 2015, an optional, supplemental individual Whole Life Insurance benefit is available to Members, Spouses, Children and grandchildren at Members' expense.

This document also describes additional benefits in Section 11 that are provided under the UA Local 190 Individual HRA Plan and Trust. That separate plan provides benefits similar to the Miscellaneous Benefits through an individual health reimbursement account. Those benefits are governed by a separate plan but are summarized here for your convenience. References made in this document to "Plan" or "Fund" generally refer to all of these plans, unless the context or a specific reference makes it clear that the plans are treated differently. If there is a conflict between that plan document and this summary, the plan document controls. That plan is administered by a Board of Trustees consisting of the same Trustees who serve on the UA Local 190 Health and Welfare Plan and Trust board and the UA Local 190 Medicare Retiree Health and Welfare Plan board, and the same Administrative Manager, and all addresses regarding notification are also the same as for the Miscellaneous Benefit administration under the Health and Welfare Plan.

If you do not find the answer to your question in this Plan and SPD, you are always welcome to call the Administrative Manager's Office with questions relating to eligibility and the Blue Cross Customer Service office for questions regarding specific benefits. The names, addresses, and phone numbers of these offices are at the end of this SPD.

We hope this Introduction will assist you in reviewing the full SPD. Please be assured we will continue to do everything we can to improve and facilitate the health program for the benefit of all Members and their families.

The Trustees

SECTION 1

GENERAL PLAN INFORMATION, INFORMATION REQUIRED BY ERISA, RIGHTS AND OBLIGATIONS UNDER THE PLAN, AND ADMINISTRATIVE RULES

Sponsoring Organizations

The organizations that authorized the establishment of the Health and Welfare Plan and the Individual HRA Plan are:

UA LOCAL 190
PLUMBERS/ PIPEFITTERS/
SERVICE TECHNICIANS/ GAS DISTRIBUTION
EIN 38-0895168
7920 Jackson Road, Suite B
Ann Arbor, MI 48103

GREATER MICHIGAN PLUMBING &
MECHANICAL CONTRACTORS
ASSOCIATION, INC.
EIN 38-6087681
58 Parkland Plaza, Suite 600
Ann Arbor, Michigan 48103

The Fund is maintained under the terms of Collective Bargaining agreements negotiated by Local 190 with participating Employers. To obtain benefits under this Fund without the requirement of self-payment, a Participant must be working for a contributing Employer. If an employer is not a party to a written agreement, then that employer has no legal obligation to contribute to the Fund on behalf of the Participants and the Participants must pay their own contributions. If there is any uncertainty about whether or not an employer is a contributing Employer, your union office should be contacted. A complete list of all Employers contributing to the Plan is available from the Administrative Manager.

Plan Names

Effective June 1, 2015, the plan that was previously called the "UA Local 190 Health and Welfare Plan" has been divided into two separate plans, one for all Members other than Medicare-Eligible Retirees and the other for Medicare-Eligible Retirees only. The plan for Members other than Medicare-Eligible Retirees continue to be known as the "UA Local 190 Health and Welfare Plan" and is sometimes referred to in this document as the "Active Plan" (even though it also covers retirees who are not yet eligible for Medicare). The separate plan that applies only to Medicare-Eligible Retirees is the "UA Local 190 Medicare Retiree Health and Welfare Plan" and is sometimes referred to in this document as the "Medicare Plan." The Individual HRA Plan name is “UA Local 190 Individual HRA Plan.”

Plan Number

The UA Local 190 Health and Welfare Plan number is 501. The UA Local 190 Medicare Retiree Health and Welfare Plan number is 505. The Individual HRA Plan number is 504.

Employer Identification Number

The employer identification number of the Board of Trustees for the UA Local 190 Health and Welfare Plan is 38-6065578. The employer identification number of the Board of Trustees for the UA Local 190 Medicare Retiree Health and Welfare Plan is 47-4017809. The employer identification number of the Board of Trustees for the Individual HRA Fund is 26-0268950.

Type of Plan

The Plans are “employee welfare benefit plans” providing health and welfare benefits under the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan's Fiscal Year

The Plan fiscal years or Plan Years begin on June 1 and end on the subsequent May 31. However, see next subheading for claim year.

Claim Year

The calendar year (January 1 - December 31) is used for tabulating the accrual of Miscellaneous Benefits, which are limited to $1,800 for each calendar year, and Prescription Medicine Benefits, which are limited to $1,440 for each calendar year. Certain benefits under the Blue Cross Blue Shield administered Health Care Plan are limited based on the calendar year, such as preventive care, chiropractic visits, and skilled nursing care. The calendar year is also used for tabulating the limits on benefits under Delta Dental and the Employee Assistance Program.

The Cost of the Plan

Employer contributions are the primary source of financing for the benefits provided under this Fund and for the expenses of Fund operations. The rate of contribution is spelled out in the collective bargaining agreements negotiated by the Union with participating Employers. These contributions are held by the Trustees under the terms of the UA Local 190 Health and Welfare Trust and the UA Local 190 Individual HRA Trust and are invested to help defray the cost of benefits and administration.

When you are working the minimum number of hours required for coverage, no money is deducted from your paycheck to pay for these benefits. However, under the terms of the Plan, a Participant may make self-payments to retain eligibility if temporarily disabled or if the Participant does not work enough hours with a qualifying Employer to satisfy the eligibility provisions; in addition you have self-pay rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). 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 Spouse and Children.

Plan Sponsor and Administrator

This Plan is operated by a Joint Board of Trustees consisting of Trustees elected by the Union and appointed by the Associations. The Board of Trustees is the "plan sponsor" and the “plan administrator” of the Plan, as defined in the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees’ address for all purposes is the address of the Administrative Manager. See **Administrative Manager**, below.

Trustees elected by UA Local 190 - Plumbers/ Pipefitters/ Service Technicians/ Gas Distribution:

David Forbes
Kevin W. Groeb
Andrew Fielder
Douglas Mayher, Jr.

Alternate: Jeffrey M. Henry.

The principal place of business for these trustees is:

UA Local 190 - Plumbers/
Pipefitters/ Service Technicians/
Gas Distribution
7920 Jackson Road
Suite B
Ann Arbor, Michigan 48103

Trustees appointed by the Greater Michigan Plumbing & Mechanical Contractors Association, Inc. and their principal places of business:

Sandra L. Miller
Greater Michigan Plumbing & Mechanical Contractors Association, Inc.
58 Parkland Plaza, Suite 600
Ann Arbor, Michigan 48103

John T. Darr
John Darr Mechanical, Inc.
293 Dino Dr.
Ann Arbor, Michigan 48103

Michael D. Darr
Boone and Darr Incorporated
4465 South State
Ann Arbor, Michigan 48108

Jeremy Finn
John Darr Mechanical, Inc.
293 Dino Dr.
Ann Arbor, Michigan 48103

Agent For Legal Process

The agent for legal process for the Plan is the Plan's legal counsel, which is:

Ferguson Widmayer PC
538 North Division Street
Ann Arbor, Michigan 48104
ATTENTION: Warren J. Widmayer

Service of process also may be made on the Board of Trustees, which is also the Plan Administrator, at the following address:

UA Local 190 Health and Welfare Board of Trustees
c/o TIC International Corporation
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025

Other Rules of Administration

The Board of Trustees may adopt any rules for administration of the Plan it considers desirable, provided they do not conflict with the Plan, and may correct errors or defects, supply omissions and reconcile inconsistencies to the extent necessary to effectively administer the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and persons covered by this Plan may examine records pertaining directly to themselves.

The Board of Trustees, as Plan Administrator, has discretionary authority to determine the status and rights of Participants, Beneficiaries and other persons, to construe and interpret Plan terms, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, hire professionals and generally to do all other things needed to operate, manage and administer the Plan. The discretionary authority granted to the Plan Administrator is intended to be broad and entitles the Plan Administrator to deferential judicial review of the Plan Administrator's decisions pursuant to the U.S. Supreme Court's decision in Firestone Tire and Rubber Co. v. Bruch. This means that the Board of Trustees' actions, when performed as Plan Administrator, can be overturned by a court only if the action was arbitrary or capricious.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan.

Blue Cross Blue Shield administers medical Basic Benefits under the Plan, and it is the named fiduciary for Basic Benefits claims administration. Delta Dental USA administers Dental Benefits under the Plan, and it is the named fiduciary for Dental Benefits claims administration. Both the decisions made by Blue Cross Blue Shield and the decisions made by Delta Dental USA are subject to final appeal to the Board of Trustees as Plan Administrator. Certain other benefits of the Plan are provided pursuant to insurance policies purchased by the Plan Administrator from various insurance companies, or through contracts for services with other providers. These insurance companies and other providers are the named fiduciaries for claims administration of their respective benefits. The Plan Administrator retains all its other authority, including appeals of claim denials. Effective January 1, 2014, these claims and appeals procedures will be changing to include additional provisions for internal claims review and to add provisions for external claims review by an independent party for final review of claims.

Administrative Manager

The Board of Trustees retains all discretion and authority to make final decisions under the Plan and is considered the "Plan Administrator" under ERISA. However, daily operation of the Plan is carried out under a contract with an Administrative Manager. All correspondence to the Plan Administrator, Administrative Manager, or Board of Trustees should be sent to the Administrative Manager's office, which is the official address for the Plan.

The Administrative Manager for the Plan is:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025

EIN 13-2600875

Toll-free phone number: 1-888-390-PIPE (7473)

Certain documents are identified in this summary as available for review at the Union Business Office. The Union Business Office address is:

UA Local 190 - Plumbers/ Pipefitters/ Service Technicians/ Gas Distribution
7920 Jackson Road
Suite B
Ann Arbor, Michigan 48103

Fund Office

The Fund Office is the office of the Administrative Manager:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025

Fund Website

The Fund maintains a web site at which additional information, announcements, summary annual reports, and forms are available. The current version of this Summary Plan Description is also available there. The address of the Fund web site is http://www.ua190benefits.org.

Attorney for Fund

The attorney for the Fund is:

Ferguson Widmayer PC
Attn: Warren J. Widmayer
538 North Division
Ann Arbor, Michigan 48104

Collective Bargaining Agreements

The Health and Welfare Trust ("Fund") was established and is maintained under the terms of collective bargaining agreements. The agreements describe the conditions under which the participating Employers are required to contribute to the Fund and the rate of contributions. Upon written request, Participants and other persons covered by this Plan may examine the agreements at the offices of UA Local 190 or the Administrative Manager's office. Participants may request copies of the agreements from UA Local 190 - Plumbers/Pipefitters/Service Technicians/Gas Distribution, 7920 Jackson Road, Suite B, Ann Arbor, MI 48103.

Fund Medium for the Accumulation of Fund Assets

All contributions and investment earnings are accumulated by the Fund. Effective June 1, 2015, basic Life Insurance Death Benefit and Accidental Death and Dismemberment insurance is provided by the Metropolitan Life Insurance Company ("MetLife") in return for coverage premiums paid by the Fund. Effective December 1, 2015, optional supplemental group term life and accidental death and dismemberment insurance is provided by MetLife and optional supplemental individual whole life insurance is available through Texas Life Insurance Company. Employee Assistance Plan benefits are provided by Magellan HRSC, Inc. in return for coverage premiums paid by the Fund. These companies agree to provide all benefits in return for the premiums we pay, and the Fund is not at risk for any amounts other than the premiums for these benefits. The Fund is not at any risk for amounts paid for supplemental group term life and supplemental group accidental death and dismemberment insurance or supplemental individual whole life insurance since those premiums are paid solely by Members.

All other benefits are "self-funded," which means they are paid from the employer contributions and earnings on those contributions, which are held in the separate Trust Funds for the Plans. Although Blue Cross Blue Shield administers payment of Basic Benefits, the money for payment of claims comes from the Fund, not Blue Cross Blue Shield. Similarly, although Delta Dental administers payment of Dental Benefits, the money for payment of claims comes from the Fund, not Delta Dental.

Interpretation of Plan Provisions

No one has the authority to speak for the Trustees in explaining the eligibility provisions or benefits of the Plan, except the full Board of Trustees or the Plan's Administrative Manager to whom such authority has been delegated.

No plan provision or interpretation of the Plan is official unless it is issued in writing. No interpretation of the Plan can change the Plan's terms, and any interpretation of the Plan that is not consistent with the Plan is invalid. Interpretations of the Plan must be consistent with the Plan documents, which contain the official rules of the Plan.

Benefits Are Not Payable if Motor Vehicles Are Involved

The Fund does not provide coverage for any incident involving a motor vehicle, as defined in Section 9's Motor Vehicle Accident Injury Limitations and Exclusions.

Workers' Compensation Claims

Medical and hospital costs resulting from any injury/illness that is sustained during the course of any employment for wage or profit are **not** covered by the Plan. In certain instances, subject to review and approval by Fund Legal Counsel, an agreement may be signed that permits the Fund to pay for services and supplies provided as the result of the work-related injury/illness, subject to reimbursement whenever you collect benefits or are compensated by another source. If the claim is work-related, the Fund will require reimbursement from you or Workers' Compensation. This agreement protects the Fund during the period of time the Participant is pursuing claims through the Workers' Compensation system, against an Employer's liability carrier, through an Occupational Disease Fund, and/or against a manufacturer. Coverage is limited to the types of services and supplies normally covered by the Plan. Additional information and the actual agreement can be obtained from the Administrative Manager's Office. While you are on Workers' Compensation and unable to work, you may continue your Plan coverage for all other benefits under the self-pay rules.

Asbestos and Toxic Substance Exposure and Related Diseases

Any injury/illness that is the result of exposure to asbestos, chemical agents or other toxic substances is not normally covered by the Plan. In certain instances, subject to review and approval by Fund Legal Counsel, an agreement may be signed that permits the Fund to pay for services and supplies provided as the result of the exposure and/or related disease. If the claim is work-related, the Fund will require reimbursement from you or Workers' Compensation. This agreement protects the Fund during the period the person covered by this Plan is pursuing claim through the Workers' Compensation system, against an Employer's liability carrier, through an Occupational Disease Fund, and/or against a manufacturer. Coverage is limited to the types of services and supplies normally covered by the Plan. Additional information and the actual agreement can be obtained from the Administrative Manager's Office.

Payment of Benefits

Your coverage consists of services and supplies for which the Fund agrees to pay under the terms of your coverage documents. Payable services and supplies, as outlined in this Summary Plan Description ("SPD"), are called benefits.

Medical Necessity

A service that you receive from a medical provider must be medically necessary in order to be payable under your health care coverage. The guidelines for determining medical necessity are specified in Section 25, Definitions.

The Plan pays only for those services and supplies that are a medical necessity for the treatment of an injury/illness covered by the Plan, unless coverage is otherwise specifically provided by inclusion in the Plan. The Plan will not pay for any services or supplies for which the Participant is not required to pay.

Filing Limitation for Claiming Benefits

All claims for Basic Benefits must be submitted within 15 months from the date of service, except for hearing care claims, which must be submitted within 24 months from the date of service. Failure to file such claims within these time periods shall invalidate the claim unless it was not reasonably possible to file the claim within these time

frames. Other deadlines apply for filing claims for other benefits. **Effective upon distribution of the Benefit Advisor Card in August, 2012, all claims for reimbursements under Miscellaneous Benefits, Prescription Medicine Benefits, and the Individual HRA will be adjudicated through the use of a Benefit Advisor VISA card (referred to as a "Benefit Advisor Card" throughout this SPD)**. To be eligible for payment for services obtained from service providers that do not accept VISA, claims for reimbursement under Miscellaneous Benefits, Prescription Medicine Benefits and the Individual HRA must be submitted to the Fund Office by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued. Refer to Section 21, Filing Claims and Appeals, for more information about claim filing.

Your Coverage Identification Cards are Important

Once you enroll you will receive a Blue Cross Blue Shield identification card, a Delta Dental identification card, and a Benefit Advisor VISA Card. When you receive services, always present your card to the provider. You must present your Blue Cross Blue Shield identification card when filling prescriptions for the Plan to properly track expenses and provide you the maximum discounts available from Blue Cross Blue Shield. The numbers on your identification cards, especially the contract number, are very important in identifying your type of coverage. Be sure to sign the signature strip immediately.

You may request additional cards, without cost, for your eligible Children and Spouse. Remember, only you and your eligible Children and Spouse may use the card issued for your contract. Lending your card to anyone not eligible to use it is illegal.

Make sure you carry the most current card. Using outdated cards delays payment of claims.

If your card is lost or stolen, you can still receive services, but report the loss of your card immediately to the Administrative Manager or to a Blue Cross Blue Shield or Delta Dental representative. You will be charged a $10.00 fee if you need a replacement Benefit Advisor Card. Your customer service phone numbers and addresses are listed at the end of this SPD.

Customer Service

If you have questions about your Blue Cross Blue Shield coverage, please contact a Blue Cross Blue Shield customer service representative (see the end of this SPD for phone numbers and address).

To help the customer service representative service you better, here are some tips to remember:

- Blue Cross Blue Shield needs to know your contract number to help you with your inquiry. Your contract number can be found on your Blue Cross Blue Shield ID card.
- In addition to your contract number, Blue Cross Blue Shield would like to have a daytime telephone number where you can be reached, if possible.
- If you are questioning a service, Blue Cross Blue Shield will need the Patient's name, name of the provider (i.e., Hospital, doctor, lab, etc.), date of service, type of service and charge(s).
- When sending bills, forms or other papers, please make copies of them before you send them. Send the originals to Blue Cross Blue Shield and keep the copies for your records.
- When visiting one of Blue Cross Blue Shield's customer service offices, please bring a copy of any bills, forms or other material related to your inquiry.

If you have questions about your Delta Dental coverage, please contact a Delta Dental customer service representative (see **Section 23** of this SPD for contact information).

Explanation of Benefits

An Explanation of Benefits (EOB) will be sent to you after you receive services and Blue Cross Blue Shield or Delta Dental has processed your claim. The EOB shows you what services have been paid by Blue Cross Blue Shield or Delta Dental and what, if anything, you owe. It is not a bill.

If your claim is denied, the EOB will explain why the service or part of the charge was not covered. Please check this form carefully to make sure that you received the services listed. It is very important that you notify Blue Cross Blue Shield or Delta Dental if you did not receive the services or if there are any discrepancies.

Health Care Tips: How You Can Help Reduce Costs

The cost of health care affects everyone--even those with health care coverage. That's why it is so important that each of us takes an active part in controlling costs and keeping health care affordable for everyone.

Here are some important tips to remember:

1. **Use Participating Providers.**
Participating providers have chosen to work closely with Blue Cross Blue Shield and Delta Dental to help hold down rising medical costs. When you choose a participating provider, you limit your own out-of-pocket expenses and support our cost containment efforts.

2. **Select a personal Physician.**
It's important to have one physician that you see on a regular basis. Most people use either their family practitioner or an internist as their personal physician or "family doctor." Let your physician get to know you, your medical history and lifestyle. Your personal physician can then take care of you for regular checkups as well as referring you to specialists or coordinating your hospital care when it is necessary. Be sure to select a physician who makes you feel comfortable and whose specialization meets most of your day-to-day health care needs.

3. **Understand your Health Care Benefits.**
Use this SPD and the detailed Benefit Schedule, available upon request, as guides to know exactly what services are covered before you need to use them. Learn the meaning of terms such as co-payment and lifetime dollar maximum.

Become familiar with your coverage before a medical crisis occurs.

4. **Ask questions.**
Feel free to ask your physician questions. It's important to know how much office visits cost, if recommended tests are necessary, or if a prescribed medication has possible side effects.

If your physician recommends hospitalization or surgery, ask these questions: Is hospitalization necessary? Can tests be done before the hospital admission? Can surgery be done on the day of admission, or on an outpatient basis?

Always insist on quality care. Asking questions makes you aware of all the options available to you. Discuss your options with your physician so you can make an informed decision.

5. **Use emergency rooms for emergencies only.**
Unless your problem is a true emergency, it is less costly for you to visit an urgent care clinic or physician's office than to seek treatment in an emergency room. Because emergency rooms must have specialized staff and equipment to handle true emergencies, they are one of the most expensive places to receive medical care. The emergency room is the best place to go when you are faced with a life-threatening emergency or Accidental Injury, but when the problem isn't as serious, visit a clinic or your doctor's office. <u>If you go to an emergency room and it is not an emergency, it will not be paid for</u>.

6. **Use your Benefits efficiently.**
The **best** health care isn't always the most **expensive** care. That's why you need to consider the value of "managed care" or "health care management." For example, when you need medical assistance, you may want to ask your doctor about home health care instead of costly hospitalization. Home health care is an example of efficient use of your benefits because you receive the medical care you need in the less expensive and familiar surroundings of your own home.

7. **Stay healthy.**
The best way to protect your health is to maintain a healthy lifestyle. Use good sense in maintaining a balanced diet, exercising regularly, wearing your seatbelt and avoiding the use of tobacco and the abuse of alcohol. Pay attention to the warning signs your body gives you. When you follow good health rules, you avoid habits and activities that put you at risk for disease and injury.

As an added benefit, Blue Cross Blue Shield has teamed up with Weight Watchers®. As a Blue Cross Blue Shield member, you receive a special discounted membership in community Weight Watchers' meetings near you. Just show your Blue Cross Blue Shield ID card.

8. **Look over your medical bills.**
Doctors' offices and hospitals can make mistakes, so it's smart to look at your bills closely. Make sure you aren't billed for services you didn't receive. If you do find an error, let your physician or hospital know about it right away. If you don't receive quick satisfaction, call the Administrative Manager's Office.

9. **Help prevent fraud.**
Each year, health care fraud costs employers and employees $100 billion nationwide. That's why it's so important to check your bills and Explanation of Benefits notices to make sure you received the services listed. Never let someone else use your Blue Cross Blue Shield ID card. If you suspect fraud, please call the Blue Cross Blue Shield Anti-Fraud Hotline. The phone number within Michigan is 1-800-482-3787. If you are outside Michigan call the main switchboard at 313-225-8100 and ask for the fraud unit. All calls in Michigan are toll free, and you do not have to identify yourself. Your call may help Blue Cross Blue Shield recover funds.

Plan Changes

The Board of Trustees reserves the right to amend or modify the Plan and/or terminate the Plan or individual coverages or programs under the Plan at any time for any reason. The Trustees make amendments or modifications to the Plan by a resolution adopted in accordance with the established procedures of the Trustees and recorded in the form of a written amendment or meeting minutes, or by such person(s) as the Trustees may designate. Any such amendment shall be effective as of such date as the Trustees or their designee shall determine and may be passed with retroactive effect to the extent permitted by ERISA and the Internal Revenue Code. If there are assets in the Plan at the time the Plan is terminated, they will either be used to pay benefits or expenses of Plan administration until there are no remaining assets, or they will be transferred to another benefit plan benefiting substantially the same Members as were benefited by this Plan. No such assets will be returned to the Employers.

A summary describing any amendment to the Plan will be distributed to all Plan Participants. Such a summary may be in the form of revised pages of this SPD. If you receive revised pages, follow the instructions you receive for removing and replacing pages of this booklet, so you always have the most current version.

Forms and Agreements Necessary Under the Plan

Your Enrollment Form must be executed before the date you become eligible to participate in the Plan. If this is not done, eligibility will not begin until the Administrative Manager receives the Enrollment Form.

You must update your Enrollment Form to reflect changes in Spouse or Children within 30 days of the change. If you do not do so within the required time, coverage may be delayed until the first day of the month after the Enrollment Form is submitted and approved by the Fund Office.

The Administrative Manager has the right and authority to establish any forms or agreements it finds necessary to administer the Plan's day-to-day operation. Any such form may contain reasonable procedures, deadlines and other requirements created by the Administrative Manager to efficiently operate the Plan. Further, the Administrative Manager has the authority to enforce the use of these forms or agreements by Participants.

Other Important Administrative Provisions

Following are some other important administrative provisions:

Waiver. Failure by the Plan or Plan Administrator to insist upon compliance with any provision of the Plan at any time or under any set of circumstances does not waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan is valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

Facility of Payment. When any person entitled to benefits under the Plan is under legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the benefits that would otherwise be payable to such person will be paid to such person's legal representative for the person's benefit or be applied for the benefit of such person in any other manner that the Plan Administrator may determine. Such payment of the benefits shall completely discharge the liability of the Plan and Plan Administrator for such benefits.

Addresses, Notice, Waiver of Notice. Each Participant must file with the Administrative Manager in writing his or her post office address and any change of post office address. Any communication, statement or notice addressed to the Participant (or the Participant's Beneficiaries) at the last post office address as filed with the Administrative Manager will be binding upon the Participant (and the Participant's Beneficiaries) for all purposes of the Plan, and neither the Board of Trustees nor the Administrative Manager shall be obliged to search for or ascertain the whereabouts of any such person. The person entitled to notice may waive any notice required under the Plan.

Designation of Administrative Authority. The Plan Administrator may appoint one or more persons to assist in the administration of the Plan. Any person, including Participants, will be eligible for such appointment to assist in the administration.

Services of the Plan. The Plan Administrator may contract for legal, actuarial, investment, advisory, medical, accounting, clerical and other services to carry out the Plan.

Transfer of Benefits. No benefit under the Plan may be voluntarily or involuntarily assigned or transferred to someone else unless otherwise provided for by the Plan.

Liability of Administrative Personnel. Neither you as a Participant, your Employer, a sponsoring Union, contributing Employer, nor any of their respective Associations, officers, shareholders, directors, agents or representatives shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the willful misconduct of the party to be charged or is due to the failure of the party to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims.

Status of Benefits. The Trustees believe that the Plan is in compliance with the Internal Revenue Code and that it provides certain benefits to Participants. The Plan has not been submitted to the Internal Revenue Service for approval and, thus, there can be and is no assurance that intended benefits will be available on a tax-free basis as intended. By accepting benefits under the Plan, you as a Participant agree to be liable for any tax that may be imposed with respect to those benefits, plus any penalty and interest that may be imposed.

No Right to Anticipate Benefit. No Participant, other covered person, or Beneficiary shall have any right, title or interest in any benefit provided under the Plan prior to the payment thereof to such person, nor shall benefits be subject to garnishment or attachment, but may be subject to an authorized subrogation or assignment.

Litigation. In any action or proceeding regarding the administration of the Plan, Participants or former Participants, their Beneficiaries, or any other person having or claiming to have an interest in the Plan shall not be necessary parties and shall not be entitled to any notice of process. Any final judgment which is not appealed or appealable shall be binding and conclusive on the parties hereto and all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Plan Administrator, the Administrative Manager or an organization providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person, or if a legal action arises because of conflicting benefit claims, the cost to the Plan Administrator, the Administrative Manager or such other organization defending the action will be reimbursed by the Fund. No Participant, Beneficiary, or any other person or entity claiming to have an interest in the Plan may sue the Plan Trustees or any other party related to Plan administration unless and until that person or organization has completely exhausted the claims and appeals procedures of the Plan. You have a two year period following exhaustion of the claims and appeals procedures of the Plan in which to file a legal action against the Plan Administrator, the Administrative Manager or any organization providing benefits under the Plan, after which all claims will be barred.

Mistake of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

No Vested Interest. Except for the right to receive any benefit payable under the Plan, no person has any right, title or interest in or to the assets of the Fund because of the Plan.

Governing Law. The Plan shall be interpreted under federal law, including ERISA, and under the laws of the State of Michigan to the extent not preempted.

Severability. If any provision of the Plan is held invalid or unenforceable, the invalidity or unenforceability will not affect any other provision, and the Plan will be construed and enforced as if the invalid or unenforceable provision had not been included.

Headings and Captions. The headings and captions set forth in this document are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Participation in the Plan Creates No Obligation For Employment

The Plan shall not be deemed to constitute a contract between you and your Employer nor to be consideration or an inducement for your employment. Nothing contained in the Plan creates new employment rights or expands your rights beyond the provisions of the collective bargaining agreement between the Union and the Employers.

Administering Qualified Medical Child Support Orders

The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of Section 609 of ERISA. A medical child support order is any judgment, decree or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction or issued by an agency (in Michigan, the Friend of the Court) pursuant to an administrative process established under State law and which has the force and effect of law under applicable State law which (1) relates to the provision of child support with respect to the child of a Participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan, or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits payable with respect to a Participant or beneficiary under a group health plan. For purposes of this section, an "alternate recipient" shall mean any child of a Participant who is recognized by a qualified medical child support order as having the right to enrollment under a group health plan with respect to such Participant.

Any such qualified medical child support order must clearly specify the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order, a reasonable description of the type of coverage to be provided under the group health plan to each such alternate recipient or the manner in which such type of coverage is to be determined, the period to which such order applies, and each plan to which such order applies.

Any such qualified medical child support order shall not require the Plan to provide any type of benefit or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of the law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the qualified status of medical child support orders. If the Plan Administrator determines that the requested health care coverage is not available, and it received Notice of the order pursuant to the National Medical Support Notice Procedure, the Plan Administrator will complete "Part A-Employer's Response" and forward it to the issuing agency. Otherwise, within a reasonable period of time after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. In the case of orders issued under the National Medical Support Notice Procedure, the Plan Administrator will do so within 40 business days of the date of the Notice, or sooner, if reasonable, and will complete "Part B-Plan Administrator Response" and forward it to the issuing agency. The Plan Administrator will notify the Member and each alternate recipient, the custodial parent (if other than the Participant) and the issuing agency, if applicable if it determines that the order or Notice is not qualified and will provide specific reasons for the decision. If the Participant or any affected alternate recipient disagrees with the determination of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Upon determination that the Notice or order is qualified, the Plan Administrator shall notify the Participant, each alternate recipient, the custodial parent (if other than the Participant), and the issuing agency (if applicable) that coverage is or will become available, the effective date of such coverage or if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision of the State substituted for the name of the child) to activate the coverage. In addition, the Plan Administrator will furnish the custodial parent a description of the coverage available, including, if not already provided, a copy of this SPD and any forms, documents or information necessary to activate the coverage.

If the Plan Administrator determines that the order or Notice is qualified, the plan will follow the order unless or until compliance with the order would violate legal restrictions on wage withholding (if any), the Participant is no longer employed and/or eligible for the ordered coverage, it receives satisfactory written evidence that the order is no longer in effect, the alternate recipients are or will be enrolled in comparable health coverage effective no later than the date of disenrollment in this Plan, family health coverage for all employees has been eliminated, any available continuation coverage is not elected, or the period of any continuation coverage expires.

The Plan Administrator will notify the appropriate employer of any qualified order or Notice for wage withholding (if any) purposes.

Alternate recipients of a qualified medical child support order shall be treated as Children under the Plan for all purposes of ERISA.

Payments under this Plan under a medical child support order described in this section as reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian. If there has been a valid assignment of benefits to the state under Medicaid under applicable state law, payment will be made to the state.

Coordination of Benefits (COB)

All benefits except for Life Insurance Death Benefits and Accidental Death and Dismemberment Benefits are subject to Coordination of Benefit provisions, which help achieve full payment but prevent duplicate payment. Refer to Section 22, Coordination of Benefits and Subrogation, for more information.

Trustee Authorities

The Trustees have the authority to interpret the specific provisions of this Plan.

The Trustees give the Plan's Administrative Manager the discretionary power and authority to construe terms of the Plan and determine eligibility for benefits, subject to the right of final appeal to the Board of Trustees pursuant to the procedures for claims and appeals contained in this SPD. The Administrative Manager's decisions in these discretionary matters are to be given due deference.

The Trustees shall have the right and opportunity to have the person whose injury or sickness is the basis of the claim examined by a licensed physician when, in their opinion, it is necessary to determine the validity of the claim.

The Trustees have the right and authority to:

- Amend the Plan, including eligibility provisions, modify the schedule of benefits, purchase or terminate insurance contracts, enter into provider arrangements, delegate responsibility for benefit determination, establish cost containment programs, and engage individuals or firms to assist in the management of the Fund at any time they deem necessary.

- Refuse payment of any claim they feel may be fraudulent or any claim that is not satisfactorily authenticated or documented.

- Assess penalties for failure to provide correct and accurate information for the processing of benefit payments when such failure results in the need to recalculate claim payments or recover overpayments.

- Assess penalties if checks that are submitted for payments are returned due to insufficient funds.

- Refuse payment of benefits to any covered person related to a Participant when an existing overpayment of benefits has not been repaid.

Participant Rights

In addition to rights specified elsewhere in this SPD, the Participant has the right to select his or her own physician, surgeon and provider of service, subject to the benefit limitations that may exist if a participating provider also provides the same service or supply. A physician-patient relationship shall be maintained, and a signed authorization for the release of information is required for insurance company and Trustee access to medical records.

The Participant has the right to designate a Beneficiary. The Participant shall automatically be deemed to be the Beneficiary for the payment of any benefits of an eligible Spouse or Child, and no eligible Spouse or Child shall be entitled to designate a Beneficiary.

Also, as a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants and other persons covered by this Plan shall be entitled to:

- Examine, without charge, at the Administrative Manager's Office all Plan documents, including the Plan, the Trust, collective bargaining agreements, insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Manager. The Administrative Manager may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of the summary annual report upon request.

- Obtain from the Administrative Manager, without charge, a copy of the Plan's procedures regarding Qualified Medical Child Support Order (QMSCO) determinations. Issues involving these orders may be resolved in Federal court.

- Continue health care coverage for yourself, Spouse or Children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse and Children may have to pay for such coverage. Review this summary plan description (see **Section 20, COBRA Continuation of Health Coverage**) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- The reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) (unless you are under the age of 19) after your enrollment date in your coverage. The requirement to provide certificates of creditable coverage applies through December 31, 2014. (See **Section 15, Pre-Existing Conditions**)

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan Participants and beneficiaries.

No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. You may also file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Manager.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Administrative Manager's office.

If you have any questions about this Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Procedures for Recovery of Overpayment

When it is discovered that a claim has been overpaid, the Participant will be notified of the overpayment and requested to refund the overpayment amount.

In the event the check was recently sent directly to the provider, an attempt will first be made to recover the check, uncashed, from the provider or to obtain a refund from said provider.

Any reasonable procedure designed to expedite recovery of overpayments and minimize the risk of loss to the Fund may be employed after the initial notice of overpayment has been given to the provider or Participant. Absent a determination by the Trustees or Administrative Manager that an expedited procedure should be followed to minimize risk of loss to the Fund, the following procedure shall be followed:

> If neither the provider nor the Participant returns the check or refunds the overpaid amount, a second notification will be sent after 30 days to the Participant. If after an additional 30 day period the overpayment still exists, any benefits that would otherwise have been payable for charges incurred by the Participant or any covered Child or Spouse will be applied towards the overpayment until the entire overpaid amount is recovered. If a provider who is overpaid refuses to return the overpayment, the Trustees may initiate or request that Blue Cross Blue Shield or Delta Dental initiate recovery in the form of offsets of any other amounts owed to the provider, until the overpayment is recovered. The Trustees may, in their discretion, either seek reimbursement directly from such Participant with respect to such expenses or request a Participant's Employer to withhold such amounts proportionately from such Participant's future wages and turn over such amounts to the Plan until the amount owed to the Plan has been recovered. The provider and the Participant will be notified in writing that this action has been taken.

Fund Legal Counsel may become involved in collection attempts of overpaid claims at any point in this process. Fund Legal Counsel will be kept informed of any payments received or claims applied to the overpayment.

All notification letters sent to the Participant will include the specific amount of the overpayment, the reason for overpayment and amount of reprocessing fee due, if applicable.

Participant Responsibilities

While the Trustees take every reasonable effort to make certain that Participants receive all benefits to which they are entitled, the ultimate responsibility rests with the Participants. Certain things must be done to protect and assure receipt of benefits. A Participant:

- Must complete the Coordination of Benefits questionnaire once each year and file it with the Administrative Manager's Office promptly.

- Must notify the Administrative Manager's Office anytime the Participant has a change of address, change in marital status, a death of a family member of a covered person, a change in Spouse or Children, or a change in other health care coverage.

- Should complete a Participant Data Form to designate or change his or her Beneficiary and file it with the Administrative Manager's Office.

- Is expected to familiarize himself or herself with the eligibility and benefit provisions of the Plan.

- Must make any required self-contributions or self-payments on time and in the correct amounts. To protect the Fund from abuse, the Trustees cannot accept self-payments or self-contributions after claims have been incurred.

- Is expected to fully cooperate, submit to medical examinations as often as is reasonably necessary, and release medical records to the Fund. Failure to cooperate shall constitute a basis for denying a claim.

- Must provide all information requested on the claim form and any additional information that may be requested by the Administrative Manager's Office. This will avoid unnecessary delays in processing the Claim.

- Must file all Basic Benefit claims within 15 months from the date services or supplies are provided, except for hearing claims, which must be filed within 24 months of receiving service, and must file all Miscellaneous Benefit, Prescription Medicine Benefit, and Individual Health Reimbursement Account Benefit claims by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued.

- Is expected to cooperate with the Administrative Manager's Office in the investigation of any fraudulent claim or any claim that is not satisfactorily documented.

- Is urged to obtain the proper motor vehicular coverage to protect the Participant and the Participant's Spouse and Children in the event of a motor vehicular related accident or incident, because no Basic Benefits are paid by the Fund for injuries or claims arising from motor vehicle accidents.

- Should use the Blue Cross Blue Shield, Delta Dental and Benefit Advisor cards that are available from the Administrative Manager's Office or at the Participant's local union whenever treatment is provided.

- Is expected to provide the Administrative Manager's Office with a copy of a marriage license, complete copies of all divorce papers, copies of birth certificates for Spouse and Children and appropriate documents as proof of continued eligibility of Spouse and Children.

- Is expected to participate in any hospital bill review program by completing appropriate forms and questionnaires regarding inpatient confinements.

- Is expected to participate in all cost containment programs adopted by the Fund.

Privacy of Protected Health Information

Information gathered by the health and dental portions of the Plan (all benefits other than Loss of Time, Life Insurance Death Benefit, and Accidental Death and Dismemberment Benefits) is protected by law from unnecessary disclosure. Specifically, health information that is individually identifiable (information that includes items that can be used to determine who the information relates to) is "protected information." The Plan may share protected health information with the Joint Board of Trustees of the UA Local 190 Health and Welfare Plan, which is the Plan Sponsor, under the circumstances stated in this section.

There are three circumstances under which the Plan may disclose protected health information to the Plan Sponsor:

- First, the Plan may inform the Plan Sponsor whether a person is enrolled in the Plan.

- Second, the Plan may disclose "summary health information" to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims with all identifying information except the five-digit zip code removed.

- Third, the Plan may disclose protected health information to the Plan Sponsor for Plan administrative purposes. The Trustees, who as a group are considered the Plan Sponsor, are also considered, as a group, to be the Plan Administrator, and have the ultimate responsibility for operating the Plan. The Trustees fulfill this responsibility by carefully selecting professional administrators to handle most of these functions, such as enrolling Members, processing claims filed by health care providers and Members, and otherwise operating the Plan according to its provisions. The Trustees directly perform limited administrative functions necessary for the management and

operation of the Plan - particularly Plan language interpretation in specific cases, claim reviews and appeals of contested claims.

The Plan Sponsor's use and disclosure of protected health information is subject to the following restrictions:

- The Plan Sponsor will only use or disclose protected health information for Plan administrative purposes, as required by law, or as permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

- If the Plan Sponsor discloses any protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep protected health information private as required by the HIPAA regulations.

- The Plan Sponsor will not use or disclose protected health information to anyone for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor. This means that individuals will be required to separately provide protected health information to other plans if they wish to claim other benefits that are not part of the health plan, such as Loss of Time Benefits or Disability Pension Benefits, even though the health information is available under the Health or Dental Plans. The Trustees will disregard any protected health information knowledge obtained through Health Care Plan activity when making decisions under any non-Health Care Plan.

- The Plan Sponsor will promptly report to the Plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures described in this section.

- The Plan Sponsor will allow Participants or the Plan to inspect and copy any protected health information that is in the Plan Sponsor's custody and control, to the extent permitted or required by the HIPAA Regulations.

- The Plan Sponsor will amend, or allow the Plan to amend, any portion of protected health information to the extent permitted or required under the HIPAA Regulations.

- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). Participants will have a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.

- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of protected health information available to the Plan and to the U.S. Department of Health and Human Services.

- The Plan Sponsor will, if feasible, return or destroy all of protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any Business Associate when the Plan Sponsor no longer needs protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The members of the Joint Board of Trustees are the only individuals under the direct control of the Plan Sponsor who may be given access to protected health information for the purposes set forth in this document. If any Trustee uses or discloses protected health information in violation of the rules that are set out in this summary, the Trustee will be subject to disciplinary action and sanctions.

If a Trustee uses or discloses protected health information in violation of the rules that are set out in this section, the Joint Board of Trustees may discipline the Trustee. Discipline may include any action determined by the Joint Board of Trustees to be reasonably expected to eliminate the possibility of further violations, including, for example, reprimand, imposition of special security measures with respect to the violating Trustee, or removal from the Joint Board of Trustees by a vote of a majority of the Trustees serving on the Board at the time of the vote, in the sole

discretion of the Trustees, and the Trust is hereby amended to the extent necessary to allow such removal under these circumstances. If a Trustee is so removed, the Union or Association that appointed the removed Trustee will appoint a replacement.

If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to any Participant.

The Joint Board of Trustees also contracts with various consultants, advisors, and third-party administrators to provide for operation of the Plan ("Business Associates"). The Trustees will require all Business Associates to contractually agree to protect all protected health information provided to them as required by the HIPAA regulations.

The Joint Board of Trustees' Oversight Committee is also the HIPAA Committee. That committee currently consists of the following individuals:

Kevin Groeb, Trustee
Sandra L. Miller, Trustee

The HIPAA Committee is authorized to formulate privacy practices, policies and procedures, draft, review and approve Business Associate agreements, and draft, review and approve privacy notices to be provided to Plan Participants. The HIPAA Committee also is required to monitor the Plan's compliance with the HIPAA regulations. The HIPAA Committee may employ and consult with legal counsel, who may be the legal counsel for the Plan, to obtain assistance and advice in carrying out these duties.

The Joint Board of Trustees also has appointed James Schreiber of the Administrative Manager's office as the Plan's Health Care Privacy Official to provide oversight of compliance with the policies and procedures related to the protection of protected health information and federal and state regulations related to Participant privacy.

See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA. A copy of the notice is available upon request from:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Farms, Michigan 48025
(888) 390-7473

SECTION 2

ELIGIBILITY: ACTIVELY AT WORK MEMBERS

Initial Eligibility Provisions (Effective For Members Not Eligible As Of April 1, 2007 Under 120-Hour Rule)

How do I become eligible for these Benefits as a Member Actively at Work in the Local 190 jurisdiction?

You will become eligible to be covered by the Plan on the first day of the month following completion of 520 hours of covered employment within a 12-month period. This is your "eligibility date." For example, if you start working in June, and by August you have completed a total of 520 hours of covered employment, you will be eligible for coverage starting September 1, and September 1 is your "eligibility date."

The period for determining eligibility starts with your first month of work, and rolls forward until you have a consecutive 12-month period, or less, in which you are credited with 520 hours. (Covered employment means employment with an Employer bound by the collective bargaining agreement.)

If you work in a classification that is subject to a probationary period, your "eligibility date" is the first day of the month following completion of 120 hours of covered employment within a 12-month period that starts after the month your probationary period ends.

If you return to work following retirement and you are a Medicare-Eligible Retiree, your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan terminates and you become covered under the UA Local 190 Health and Welfare Plan immediately upon your return to work, without having to complete a new period of 520 hours of covered employment. Once you stop working, your coverage under the UA Local 190 Health and Welfare Plan terminates and your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan resumes.

When does my coverage actually begin?

You must complete a Member Application form and have it approved by the Administrative Manager before your coverage is effective. The application deadline is the last day of the month after the month of your eligibility date. So, in the example above, since your eligibility date is September 1, your Member Application form must be submitted and approved by the Administrative Manager by October 31. Coverage will be made effective as of your eligibility date (retroactive) only if you file your Member Application by the application deadline and the Administrative Manager approves the Member Application. If you do not file the application by the application deadline, coverage will not become effective until the first day of the month after the date on which your Member Application is filed and approved by the Administrative Manager.

What requirements must I meet to stay covered after my coverage has begun?

Meeting the original eligibility requirements results in coverage for the month beginning with your eligibility date and the following month. (In the example above, this would be September and October.)

After the first two months of coverage, you must have at least 100 hours of covered employment in an eligibility month (commonly referred to as the "work month") in order to be covered for the coverage month linked to that eligibility month. The eligibility month is the second month before each coverage month. Your initial eligibility month is the month containing the eligibility date, and the first coverage month subject to the 100-hour rule is the second month after that month. (In the example above, the first coverage month is September, the month containing the eligibility date. The first coverage month subject to the 100-hour rule is November, the second month after September.)

This table shows the months that determine eligibility for each coverage month under the 100-hour rule:

Hours Worked in this month ("Eligibility Month")	Control Coverage for this month ("Coverage Month")
November	January
December	February
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December

What if I don't work 100 hours in an eligibility month?

If you don't qualify for coverage for a particular coverage month because your hours were too low, you must make a payment under one of the self-payment programs described in this booklet and make the required self-payments on time. See **Eligibility During Periods of Unemployment (Self-Payment Provisions)**, below.

For a special exception to the 100 hours per month rule, see **One-Time Exception to 100-Hour Requirement**, below.

Non-Bargaining Unit Employees

Can Non-Bargaining Unit Employees be Participants in the Plan?

Non-Bargaining Unit Employees of an Employer may become Participants in the Plan if their Employer elects in writing that all of its Non-Bargaining Unit Employees shall become Participants in the Plan, and the Employer pays to the Trustees the same hourly rate with respect to its Non-Bargaining Unit Employees as it is obligated to pay from time to time with respect to its employees who are Members. Unless otherwise specifically provided in the Plan, Non-Bargaining Unit Employees who are Participants are subject to the same provisions of the Plan applicable to Members, except that Non-Bargaining Unit Employees are not eligible to continue under any self-pay arrangement except COBRA Continuation of Coverage. Non-Bargaining Unit Employees become eligible to be Participants on the first day of the month following completion of five consecutive months of service with their Employer or completion of five consecutive months of service after the Employer's election of coverage, whichever is later. Payment of contributions must be made during these five months. Participation shall be pursuant to a written agreement with the Trustees, which shall provide for minimum payments covering 140 hours per month.

Continuation of Eligibility

Once eligible, how do I continue to be eligible?

To continue eligibility you must work 100 hours per month or, if applicable, make a self-payments in the amount set by the Trustees. You have no coverage for medical expenses incurred after the end of the month that follows the month in which you work less than 100 hours in covered employment, unless you continue on a self-payment basis as described below. For example, if you work 100 hours in November and December but only 95 hours in January, your covered medical expenses incurred in January and February will be paid by the Plan, but expenses incurred after February will not be covered unless you reinstate coverage under the self-pay rules.

If you lose eligibility because of termination of employment or reduction of hours, you may be entitled to continuation coverage on a self-payment basis. See **Eligibility During Periods of Unemployment (Self-Payment Provisions)**, below.

One-Time Exception to 100-Hour Rule

What if I take a vacation some month and work less than 100 hours? Is there an exception to the requirement that I work 100 hours per month to remain eligible?

The Trustees recognize that Members who take a vacation from work may have a month in which they work less than 100 hours during the month when the Member takes an extended vacation. To accommodate such situations, a Member can have one month per Plan Year in which the 100-hour requirement is reduced to 60 hours due to failure to achieve the 100 hours due to vacation. To remain eligible without making self-payments in a month in which you work more than 60 hours but less than 100 hours due to vacation, you must notify the Fund Office in writing that you are electing to use your 60-hour month. Please do this as soon as you know that you will have less than 100 hours in a month, so the Fund Office does not demand that you self-pay for that month.

Termination and Reinstatement of Coverage

If my coverage is terminated, how do I again become eligible?

If your coverage is terminated (for example, you work less than 100 hours in a month and do not make the required self-payments to remain eligible), you must complete 520 hours of employment within a 12-month period after termination to again become eligible. If this is done within the first 12 months after your coverage terminates, you will not be required to file a new application, and your coverage will again commence as of the first day of the month following completion of the 520 hours. If your period of termination of coverage is more than 12 months before the 520-hour rule is fulfilled, then you must also fill out and submit a new application form when you complete the 520 hours.

You will not be covered for treatment incurred during the period of termination.

Eligibility of Spouse and Children of Actively at Work Participants

Are my Spouse and Children eligible?

If you are an Actively at Work Participant your Spouse and Children are eligible whenever you are eligible, provided the Children meet the definition of eligible Children under the Plan. See the definition of Children in **Section 25, Definitions**. Eligible covered family members include:

- Your legal Spouse.
- Through December 31, 2013, your Child or Children who are not eligible for other employment-based health coverage (other than through a parent), until their 26th birthday. Effective January 1, 2014, your Child or Children, until their 26th birthday, even if they are eligible for other employment-based coverage.
- In some cases, your Child who is disabled (see below).

Are my stepchildren eligible?

A child of your Spouse is eligible only 1) during the period you are legally married to your Spouse 2) until the child has not attained his or her 26th birthday; and 3) as long as he or she is not eligible for other employment-based coverage, other than through a parent.

When does coverage for my eligible Spouse and Children begin?

Coverage for your eligible Spouse and Children becomes effective when your coverage becomes effective if you include them in your Member Application Form at the time you apply for coverage. If you are Actively at Work and you wish to add a Spouse or Child who was not included in your original Member Application, see "Changes in Your Family and Special Enrollment Rights " in Section 9.

Eligibility of Natural and Adopted Children Who Are Disabled

What if my child is disabled?

Your Child or Children who are incapable of self-sustaining employment by reason of a mental or physical handicap may be eligible to remain covered under the Plan beyond age 26. This continued coverage is only available if all of the following conditions are satisfied: 1) the Child became incapacitated before the end of the year in which he or she reached age 26; 2) the Child is principally dependent on you for support and maintenance; and 3) upon request, you provide satisfactory documentation of the existence of the mental or physical handicap at no expense to the Fund (unless the expense is pre-approved by the Fund), no later than January 31 of the year after the year the Child attains age 26 for coverage to continue. Such documentation may include school records/reports, physician's statements, court documents or determination by the Social Security Administration. Coverage will continue as long as the Child is chiefly dependent upon you for support and maintenance due to the disabling condition.

Foster children are not eligible as Children.

Continuation Coverage for Spouse and Children

Can my Spouse and Children who become ineligible continue coverage?

Under certain circumstances, your Spouse and Children who become ineligible may be entitled to continue coverage on a self-pay basis either under a Self-Payment Program of the Fund, or under COBRA. See the remainder of this Section and **Section 20** for more information on **COBRA Continuation of Health Coverage**, and see **Section 19, Self Pay Rules**.

Eligibility During Periods of Unemployment (Self-Payment Provisions)

What is my eligibility if I am not disabled, but I become unemployed or my hours fall below 100 in a month?

If you are an eligible Participant who would otherwise lose your eligibility because you do not have Employer contributions for a sufficient number of hours remitted to the Fund on your behalf to meet the continuing eligibility requirements, you may continue eligibility by means of a Self-Payment Program provided by the Fund, through a federal law called COBRA.

Lower-Cost Self-Payment Program. The Fund's actuary determines the full-cost COBRA self-payment rate based on the average cost of coverage over the preceding year. But if you are an Actively-At-Work Member whose hours fall below 100 in a month, you may be eligible for a reduced-rate COBRA self-payment program if you meet the reduced-rate program requirements. See ***"How do I qualify for the special lower-cost Self-Payment Program*** below. Reduced-rate self-payments are made for up to 12 months out of any 18-month period at the reduced rate. See Section 19, "Self Pay Rules," for the current reduced rate.

Full-Cost Self-Payment Program ("Full COBRA Rate"). If you do not meet the reduced-rate Self-Payment Program eligibility requirements or have used up the full 12 months under that program, you may continue your coverage under the Fund under full-cost COBRA continuation of health coverage Self-Payment Program until your total combined months of reduced-payment Self-Payment coverage and COBRA Continuation Self-Payment coverage equal 18 months (for example, up to 6 additional months after the first 12 months at the lower Self-Payment rate, or the full18-month period if you did not qualify for the reduced-rate self payments). Generally, the reduced-rate self-payments period and the full –cost COBRA continuation period together cannot exceed 18 months (or as otherwise provided pursuant to the "COBRA" statute) and that 18-month period is the total required continuation period as provided by COBRA for a reduction in hours or termination of employment. Your total combined months of continuation coverage may be extended to up to 29 months if you are disabled within 60 days of the start of Self-Payment coverage and meet certain requirements for notifying the Administrative Manager. See **Section 20, COBRA Continuation of Health Coverage,** for more details.

The rates required under the Fund's reduced-rate Self-Payment Program and full-cost COBRA continuation are determined by the Board of Trustees and may be adjusted periodically. You will be advised of the applicable rates when the Administrative Manager is notified that you no longer meet the Fund's regular eligibility requirements. See Section 19, Self-Pay Rules, for the current rates and the time and place to make payments.

How do I qualify for the special lower-cost Self-Payment Program?

The special low rate is intended to help Members who are available for covered work in the Union's jurisdiction but are unable to obtain 100 or more hours of work in the trades covered by the collective bargaining agreement between the Union and contributing Employers. The special low rate is intended to reduce the hardship experienced by these unemployed and underemployed Members and their families. If you meet all of the following requirements in an eligibility month, you, as a Member or employee of the Union, qualify for the special lower rate Self-Payment Program for the related coverage month (but only for 12 months out of any 18-month period):

1. You have fewer than 100 covered hours in the eligibility month; AND

2. You are a member in good standing with the Union; AND

3. You are on the Union's "out-of-work" list; AND

4. You are not regularly working 100 or more hours in the trade for employers who do not contribute to the Plan for those hours. **Any Member who accepts regular work of 100 or more hours per month in the trade with an employer who does not contribute to the Plan for those hours will not be considered eligible for the special lower-cost Self-Payment Program.** "Work in the trade" for this purpose means work related to the underlying skills associated with a trade or craft covered by the collective bargaining agreement between the Union and contributing Employers, including any supervisory or managerial activity which is reasonably related to the underlying skills associated with such a trade or craft.

Note that the Trustees have made this lower-cost benefit available as an optional benefit, not a guaranteed right. No person acquires a vested right to such benefits. The Trustees may amend coverage, self-pay rates and otherwise exercise their discretion at any time without legal right or recourse by any person.

How long can I pay the lower-cost self payments?

The lower cost self-payment rate is available only for 12 months out of any 18-month period. The 18-month period ending before any coverage month is called the "look-back period." If you have used the lower-cost self-payment rate for 12 months out of the look-back period, you will not again be eligible for the lower-cost self-payments until the lower-cost self-payment months in the look-back period are less than 12.

Example:

Assume that you are out of work for 12 months starting with September of 2014 and you use the lower-cost self-payment program for all 12 coverage months relating to the September of 2014 through August of 2015 eligibility months. (This means that you would make self-payments for November of 2014 through October of 2015 coverage months.) You then work 100 hours in September of 2015, making you eligible for coverage for November of 2015 without a self-payment. Assume you become unemployed again and have fewer than 100 hours in October of 2015. You are NOT eligible for the lower-cost self-payment rate for the December of 2015 coverage month because you used the lower cost self-payment rate for 12 months out of the 18-month look-back period (running from June of 2014 coverage month through the November of 2015 coverage month). You remain ineligible until the first coverage month when there are less than 12 months of reduced self-payments in the preceding 18 months. In this example, that will be June of 2016, because there will only be 11 months of reduced self-payments in the period from December of 2014 through May of 2016.

When are self-payments due?

Generally, self-payments are due no later than the last day of the coverage month to which they relate. You must notify the Administrative Manager when you become unemployed by a covered Employer or subject to a reduction of hours below 100 hours per month. It is your responsibility to contact the Administrative Manager's Office to see if and when you must make self-payments to continue your eligibility.

These programs have certain election periods and requirements for timely payments. You will be advised of your rights to continue coverage under the Fund's COBRA Continuation Coverage program (under either the reduced Self- Payment rate, or the full-cost regular COBRA Continuation Coverage rate) when the Administrative Manager is notified that you no longer meet the Fund's regular eligibility requirements.

It is most important that you make a self-payment when due to continue your coverage even if you think you should be eligible by way of Employer contributions. If, after a self-payment is made, the Fund receives late contributions on your behalf that would have been sufficient to continue your eligibility, an appropriate refund of your self-payment will be made to you.

Your self-payments must be made on time. **If self-payments are not made on time your coverage will be terminated, and it will not be reinstated under the Fund's Self-Payment Program. Instead, you will be required to re-qualify under the 520-hour rule.**

Members Employed in Another Jurisdiction

See **Section 6, Special Eligibility Provisions**, subsection entitled **Reciprocity (Employment Outside the Jurisdiction of the Fund)**.

Actively at Work Participants and/or Their Spouses Who Are Age 65 or Older

What coverage is available to me while I continue to work after my Spouse or I reach age 65?

Certain federal laws regulate the coverage that must be provided to any person who is covered under the Actively at Work portion of this Plan after the person becomes eligible for Medicare benefits due to attaining the age of 65 if the Participant is Actively at Work. See **Section 17, Medicare, Supplemental Coverage, and End Stage Renal Disease**.

SECTION 3

ELIGIBILITY: RETIREES WHO RETIRE AT OR AFTER NORMAL RETIREMENT DATE

Retired Participant Benefits

Can I remain eligible for Benefits after retirement at my Normal Retirement Date?

Yes. The Trustees have established a separate program for retirees who qualify.

Note that the Trustees have made retiree benefits available as an optional benefit, not a guaranteed right. **No person acquires a vested right to such benefits, either before or after retirement**. The Trustees may amend retiree coverage, self-pay rates and otherwise exercise their discretion at any time without legal right or recourse by any person.

You, as a Member, Non-Bargaining Unit Employee or employee of the union, qualify for Plan coverage as a retiree if you

1. are entitled to a pension benefit from UA Local 190 Pension Plan; AND

2. if a Union member, you remain a member in good standing with the Union; AND you EITHER:

    a) have 35 years of vesting credit under the UA Local 190 Pension Plan; OR

    b) meet all of the following requirements:

        i) had at least three hundred seventy-five (375) hours of Employer contributions remitted to the Plan in each of the last ten (10) full Plan Years immediately before retirement (or, in Plan Years with less than 375 hours remitted, you prove to the Trustees' satisfaction that you were available for work in the jurisdiction but insufficient work was available in the jurisdiction for you to reach the 375 hours); AND
        ii) had at least ten thousand (10,000) hours of Employer contributions remitted to the Plan in the ten (10) years immediately before retirement (the "10-year look-back period"); AND
        iii) are a Participant in this Plan at the time of your retirement; AND
        iv) enroll in coverage when it first becomes available to you.

Once you decline retiree coverage, you will not be eligible again.

If you return to work following retirement and you are a Medicare-Eligible Retiree, your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan terminates and you become covered under the UA Local 190 Health and Welfare Plan immediately upon your return to work, without having to complete a new period of 520 hours of covered employment. Once you stop working, your coverage under the UA Local 190 Health and Welfare Plan terminates and your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan resumes.

What if I do not meet the retiree coverage requirements listed above?

If you do not meet the first two retiree coverage requirements listed above, you cannot obtain coverage as a retiree unless you return to work and fulfill all of the requirements listed above. If you do not meet either the requirement listed under 2.a) above, or all of the requirements listed under 2.b) i. through iv. above, you cannot obtain coverage as a retiree unless you return to work and fulfill all of the requirements listed above, or the Trustees agree to make a special exception. The circumstances that the Trustees will consider when making special exceptions will include the reasons you do not meet the requirements, and how recent and substantial was your participation in the Plan. These rules are designed to avoid adverse selection and avoid admitting retirees into Plan participation when they have not had significant contributions paid into the Plan during the years immediately preceding retirement.

Exceptions will be granted only when the Trustees determine, in the Trustees' sole discretion, that one or more of the following criteria are met:

- the retiree substantially met the requirements;
- the retiree's failure to meet all of the requirements was not material in light of the purposes of the retiree coverage requirements;
- the retiree's failure to meet all of the requirements was due to circumstances beyond the retiree's control;
- substantial and recurring contributions were made to the Plan on the retiree's behalf in most of the years leading up to the retiree's retirement.

The Trustees retain the right to deny coverage when the requirements for retiree coverage are not met.

What if I am on Disability Retirement during the ten (10) years immediately before I qualify for Normal Retirement?

If you are on Disability Retirement during any portion of the 10 years before Normal Retirement, you will be credited with hours of Employer contributions for the period of Disability Retirement as follows:

You will be credited with the greater of the following for each year (pro-rated for fractions of a year) that you draw Disability Retirement Benefits during the 10-year look-back period used for determining retiree health eligibility:

- the average hours of Employer contributions paid to the Plan by Employers for you during the years (pro-rated for fractions of a year) in the 10-year look-back period before you began to draw Disability Retirement Benefits; or
- 1,000 hours of Employer contributions for each year (pro-rated for fractions of a year) that you draw Disability Retirement Benefits during the 10-year look-back period.

Plan Programs Available to Retirees

What Plan programs are available to me and my Spouse and Children after I retire?

Upon retirement, provided the qualifications are met, you as the retired Participant and after your death, your unmarried Surviving Spouse and Children, will be eligible to continue coverage under one of the following retired Participant Self-Payment Programs:

- Retiree Self-Payment Program.
- Totally and Permanently Disabled Self-Payment Program.
- Early Retiree Self-Payment Program.
- Surviving Spouse and Children Self-Payment Program.
- Supplement to Medicare Program.
- COBRA Continuation of Health Coverage.

A brief description of the qualifications and benefits for each of the programs is set forth in appropriate sections of this Summary Plan Description. Full information is available from the Administrative Manager's Office.

Method of Payment for Coverage

How do I pay for coverage as a Retiree?

Self-payments are required to provide coverage under all of these programs. The self-payment rates are established by the Trustees, may be changed from time to time, and may be different for different self-payment Programs. The current self-payment rates can be obtained from the Administrative Manager's office. See **Section 19, Self Pay Rules** for payment time and place.

Coverage for Retired Participants' Spouse and Children

Are my Spouse and Children covered when I retire?

A Spouse or Child may also be covered through the Retiree Self-Payment Program, but the Spouse or Child must obtain coverage under the Plan at the time of the Participant's retirement. Otherwise, the Spouse or Child becomes ineligible. If the Spouse or Child is also eligible for Medicare, coverage will be provided for the Spouse or Child under the Supplement to Medicare Schedule of Benefits. A Medicare-eligible covered Spouse or Child will be treated as having obtained both Medicare Part A and Part B coverage.

Differences in Coverage for Medicare-Eligible Retirees

Are there any differences in coverage for Medicare-Eligible Retirees?

A Medicare-Eligible Retiree Member and the Member's covered Spouse and/or Child will not have prescription medicine expenses count toward the TrOOP annual out-of-pocket limit. If you are Medicare-eligible but not a retiree, your prescription medicine expenses will count toward the TrOOP annual out-of-pocket limit.

SECTION 4

ELIGIBILITY: EARLY RETIREES

Eligibility and Coverage Provisions, Payment

May I retire early and continue to be covered?

Yes, covered Participants who retire after the age of 55 and before the age of 60 are considered Early Retirees with the Fund until such time as they attain age 65 or otherwise become entitled to Medicare benefits. After that, you are entitled to purchase supplemental coverage. See **Section 17, Medicare, Supplemental Coverage, and End Stage Renal Disease**.

Your eligibility requirements for coverage and your self-payment obligation as an Early Retiree, including your Spouse and Children, are the same as eligibility requirements for coverage for normal retirement age retirees. Please see the preceding **Section 3, Eligibility: Retirees who retire at or after Normal Retirement Date**.

If, while an Early Retiree you become eligible for Medicare due to disability, your coverage will be provided under the Supplement to Medicare Schedule of Benefits. You are expected to obtain both Medicare Part A and Part B coverage.

If I am not a Participant at the time I wish to become an Early Retiree, can I still be covered?

Only if you satisfy the Trustees that you qualify for a special exception. See the preceding **Section 3, Eligibility: Retirees who Retire at or after Normal Retirement Date**.

Early Retirees' Spouse and Children

Are my Spouse and Children covered if I am an Early Retiree?

Yes, under the same conditions as coverage for Spouses and Children of normal retirement age retirees. Please see the preceding **Section 3, Eligibility: Retirees who Retire at or after Normal Retirement Date**.

Schedule of Benefits for Early Retirees

What is my schedule of Benefits as an Early Retiree?

The schedule of benefits for Early Retirees and their Spouses and Children (who are not eligible for Medicare) is the same as the schedule of benefits in effect for Actively at Work (Non-Retired) Participants, with the exception of Life Insurance Death Benefits and Accidental Death and Dismemberment Benefits (both under the basic coverage and supplemental coverage options) and Loss of Time Benefits, which are not provided.

Method of Payment for Coverage

How do I pay for coverage as an Early Retiree?

Please see **Section 19, Self Pay Rules**.

Early Retiree Reinsurance Program

Does our Plan participate in the Early Retiree Reinsurance Program?

Yes. The notice on the following page is required by law to be provided to you:

SECTION 5

ELIGIBILITY: DISABLED OR DECEASED PARTICIPANTS

Eligibility if Disabled

What if I am disabled for a period of time and can't work?

If you are injured or ill and can't work, and you were a Participant at the date of your illness or injury, your Benefits can, under most circumstances, continue under a Self-Payment Program for the same rate and eligibility period as an actively at work Member. Self-payments are made for 12 months at a reduced COBRA rate. See **Section 19, Self Pay Rules.** In addition, when you become ineligible for the Self-Payment Program, you may continue your coverage under the Fund under higher cost COBRA Continuation of Health Coverage rate.

Under unusual circumstances, you may be able to continue coverage under the reduced COBRA rate applicable to active members, but only if the Trustees agree to make a special exception. Exceptions will be granted only when the Trustees determine, in the Trustees' sole discretion that all of the following criteria are met:

- Requiring payment of the full COBRA rate would create a significant financial hardship for you;
- That substantial and recurring contributions were made to the Plan on your behalf in the most recent years leading up to your disability; and
- The circumstances under which you incurred your injury or illness were and continue to be beyond your control.

The "Self-payments" period and the "COBRA Continuation" period together cannot exceed 18 months (and comprise the total required continuation period as provided by COBRA). However, if you are determined by the Social Security Administration to be disabled within 60 days of the date you begin self-payments, this period may be extended by up to an additional 11 months (or as otherwise provided pursuant to the "COBRA" statute) if you provide timely notice to the Administrative Manager. See **Section 20, COBRA Continuation of Health Coverage.**

Eligibility if Totally and Permanently Disabled

If I am totally and permanently disabled from work, may I continue coverage for my Spouse and Children and myself?

Yes, you may continue coverage on a self-payment basis, except for Loss of Time Benefits (which are not included). When you become eligible for retirement benefits under the UA Local 190 Pension Plan (other than Disability Retirement Benefits) you lose Life Insurance Death Benefits and Accidental Death and Dismemberment Benefits, unless you convert your coverage to individual coverage at that time. When you reach age 65 or otherwise become eligible for Medicare, you may continue only Medicare supplemental coverage. Once you are a Medicare-Eligible Retiree (age 65 or older), your prescription medicine costs do not count towards TrOOP annual out-of-pocket limit. The same eligibility rules apply for your Spouse and Children as if you were retired. See **Section 17, Medicare, Supplemental Coverage and End Stage Renal Disease.**

Rules for Eligibility and Continued Coverage

What are the rules for eligibility and continued coverage as a Totally and Permanently Disabled Participant?

To obtain coverage under the Fund as a Totally and Permanently Disabled Participant, you must be receiving monthly disability pension benefits from the UA Local 190 Pension Plan.

In general, you are considered Totally and Permanently Disabled if you are no longer able to perform the duties of your job or occupation, as described and determined under the terms of the UA Local 190 Pension Plan.

If you are receiving a monthly disability pension benefit at age 60, you will convert to normal retiree status and the retiree self-payment rules will apply.

After the Social Security Administration has declared you Totally and Permanently Disabled for two years, you will be eligible to receive Medicare benefits. Once you attain the age of 65 or otherwise become eligible for Medicare, even though you will be limited to supplemental coverage, you may continue to provide coverage for your Spouse and any eligible Children under the Self-Payment Program until your Spouse attains the age of 65 or otherwise becomes eligible for Medicare and/or you no longer have any eligible Children. Note that once you become a Medicare-Eligible Retiree, your prescription medicine costs will not count towards the annual out-of-pocket limit. For this purpose, a Medicare-Eligible Retiree is defined as a retiree who is age 65 or older. If you are Medicare-eligible but are not a retiree or have not yet reached age 65, your prescription medicine costs will count towards the "TrOOP" annual out-of-pocket limit (see **"What You Must Pay"** in Section 8).

It is your responsibility as a Totally and Permanently Disabled Participant to provide the Administrative Manager's Office with a copy of your Medicare card as soon as you obtain such card. As a Totally and Permanently Disabled Participant, it is assumed you have obtained both Medicare Part A and Part B coverage when you were eligible to receive them. Your supplemental coverage applies as if you had received all Medicare Part A and Part B benefits, whether you have received them or not, so to have all available coverage you must get both Medicare Part A and Part B coverage.

Every Totally and Permanently Disabled Participant is expected to make timely application for disability benefits from Social Security and Medicare. The benefits available to you from the Fund when you are eligible for Medicare are provided under the supplement to Medicare benefits. Claims must first be submitted to Medicare and then to the Fund. If you don't sign up with Medicare, you will still only get supplemental coverage. See **Section 17, Medicare, Supplemental Coverage and End Stage Renal Disease.**

As a Totally and Permanently Disabled Participant, you must be a Participant by either Employer contributions or self-contributions on the date of disability or retirement to be eligible to be a Participant in the Totally and Permanently Disabled Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the Actively at Work Program.

Schedule of Benefits for Totally and Permanently Disabled Participants

The schedule of benefits for Totally and Permanently Disabled Participants who have not elected retirement benefits (other than Disability Retirement Benefits) is the same as the schedule of benefits in effect for Actively at Work Participants, with the exception of Loss of Time Benefits, which are not available for Totally and Permanently Disabled Participants.

Eligibility for Surviving Spouse and Children if the Participant Dies

Can my Surviving Spouse and/or eligible Children continue coverage if I die?

Yes, if you were covered as a Participant, either Actively at Work or as a retiree, at the time of your death, your Surviving Spouse and/or surviving Children may continue to obtain coverage on a self-payment basis. Your Surviving Spouse or surviving Children should contact the Administrative Manager's Office for details in this event. If your Surviving Spouse remarries, your Surviving Spouse will no longer be eligible (but your Children will). Otherwise, your Surviving Spouse may continue coverage through self-payment including supplemental coverage after becoming eligible for Medicare. No Accidental Death and Dismemberment Benefits, Life Insurance Death Benefits or Loss of Time Benefits are available, however. The same eligibility requirements for Surviving Spouses and Children must be met as if you were still a Participant.

Workers' Compensation Benefits

What if I am receiving workers' compensation benefits?

If you are receiving workers' compensation benefits, you may continue to obtain coverage on a self-payment basis, for a maximum of 36 months, which runs concurrently with the COBRA continuation coverage period. Please refer to **Section 19 - Self Pay Rules -** for the rates of coverage. Coverage is available at one rate for the first twelve months, a second rate for the second twelve months and a third rate for the third twelve months of coverage. After 36 months, you are no longer eligible for coverage.

While you are receiving workers' compensation benefits and in order to receive coverage under the Plan, you must prove you are receiving workers' compensation benefits, and must periodically provide such proof to the Fund Office in order to remain eligible to receive coverage under the Plan at the special workers' compensation rates. In addition, you must notify the Fund Office when you stop receiving workers' compensation benefits.

Once you have elected to retire (under either disability retirement or normal retirement), you must pay the retiree rates, rather than the workers' compensation rates.

SECTION 6

SPECIAL ELIGIBILITY PROVISIONS
(NOT COVERED UNDER THE ACTIVELY AT WORK AND RETIRED PARTICIPANT SECTIONS)

Military Service

What coverage is available to me if I enter military service?

Effective September 17, 2001, the Trustees resolved that, until further notice, any Member who is drafted or called into service from the reserves of the U.S. Armed Forces will have free coverage under the Plan while engaged in active duty.

If you, while a Member, are inducted into the active or reserve components of United States uniformed services **and the exception stated above does not apply to you** continuation of your health coverage under the Plan is governed by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), and the following paragraphs apply to you.

- If you are a Participant on the date of induction, your eligibility as an Actively at Work Participant will cease as of the first day of the month coincident with or next following the date you are absent due to qualifying military service for a period of over 30 days. If your absence due to military service lasts 30 days or less, you will remain eligible as an Actively at Work Participant. If you are absent due to qualifying military service for a period of over 30 days, absent an election of continuation coverage, your coverage under the Plan will terminate effective the first of the month coincident with or following 31 days of leave.

- If possible under the circumstances, you must notify the Administrative Manager of your induction in advance. Either the Member or an appropriate officer of the uniformed services may provide this notice. Advance notice is not required when military necessity prevents advance notice or other circumstances make it impossible or unreasonable to provide advance notice. In all other cases, you should provide notice to the Administrative Manager at least 30 days prior to departure for military service when it is feasible to do so. Oral or written notice is acceptable.

- A Member entering qualifying military service may elect to continue coverage, on a totally self-contributory basis, for himself/herself, Spouse and Children, assuming the Member, Spouse and Children were covered under the Plan on the day before leaving for military service, for a period of up to 24 months. The maximum period of continuation coverage due to qualifying military service is the lesser of the 24 month period beginning on the date on which the Member's absence begins, or the period beginning on the date on which the Member's absence begins and ending on the date on which the Member fails to apply for or return to a position of employment as determined under USERRA. If the Member is absent for less than 31 days as a result of military service, he or she will not be charged more than the Member's normal share of the cost of coverage.

- The COBRA provisions on electing and paying for coverage located in Section 20 of this Summary Plan Description govern in the case of electing and paying for coverage under USERRA, to the extent that such provisions do not amount to a violation of USERRA. For example, when military necessity prevents a Member from making an election of continuation coverage, or when it is impossible or unreasonable for the Member to do so, the Member will be excused from the Plan's provisions which limit the time period in which to make elections and make payments for continuation coverage, and may request reinstatement of health coverage retroactively upon the Member's election to continue coverage and payment of all unpaid amounts due. However, when a Member is not precluded by military necessity from notifying the Plan Administrator of military leave and from electing continuation coverage, and when it is not impossible or unreasonable for a Member to provide such notice and make an election, the Plan's provisions under the COBRA section govern the election of and payment for continuation coverage under USERRA.

- If the Member returns from military service and is reemployed, he or she will not be subject to any exclusion or waiting period for health insurance coverage if the exclusion or waiting period would not have been imposed had the coverage not been terminated because of military service, whether or not the Member elects or rejects continuation coverage. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

- Upon your reemployment under USERRA, your health plan coverage will be reinstated.

Self-Employed Plumbers, Pipefitters, Service Technicians, and Gas Distribution Workers (Sole Proprietorships and Partners)

What coverage is available to me if I am self-employed or a partner?

None. An individual who is self-employed as a sole proprietorship or as a partner is not considered an employee, and thus is prohibited from participating in the Plan. A business owner whose business is incorporated and who is an employee of the business is eligible.

Reciprocity (Employment Outside the Jurisdiction of the Fund)

What if I work as a Plumber, Pipe Fitter, Service Technician, or Gas Distribution Worker under another union's jurisdiction?

It is not unusual for a Plumber, Pipefitter, Service Technician, or Gas Distribution Worker to accept employment outside the jurisdiction of Local 190 when there is no work available locally.

The Plan has entered into reciprocity agreements with many other Funds covering Plumbers, Pipefitters, Service Technicians, or Gas Distribution Workers. The purpose of reciprocity agreements is to:

- Forward contributions paid into the trust fund of the other jurisdiction to the Local 190 Fund where the Plumber, Pipefitter, Service Technician, or Gas Distribution Worker is normally employed so that the Plumber, Pipefitter, Service Technician, or Gas Distribution Worker can remain eligible.

- Accept contributions transferred from other trust funds so the traveling Plumber, Pipe Fitter, Service Technician, or Gas Distribution Worker's eligibility for benefits under the Local 190 Fund will continue.

If you work in the jurisdiction of another Local, it will be necessary for you to sign an authorization and request form to transfer your hours back to the Local 190 Fund. Such a form can be obtained only from the office of the Local where you are starting work, and should be executed at the time you sign in and begin work in the other Local's jurisdiction.

This Plan, different from your pension plan, is based on hours worked, not money paid in. Therefore, your coverage as a traveler under the Local 190 Plan will depend on your qualifying for the required number of work hours. If you so qualify, you may retain eligibility whether more or less money is sent by the other trust fund than is required under the Local 190 collective bargaining agreement.

When you work outside of the UA Local 190 jurisdiction, normally we will credit you with one hour for each hour worked for which the other local reciprocates the contribution to the Fund. However, when you are working in another jurisdiction and the other local reciprocates contributions at a rate higher than that of the UA Local 190, we will credit you with the number of hours equal to the amount reciprocated divided by the rate that would apply if you had performed the work in the same classification under UA Local 190's jurisdiction.

Both Spouses Eligible as Employees

If both a husband and wife are employed as a Plumber, Pipefitter, Service Technician, or Gas Distribution Worker and are both eligible as employees to be Participants in the Plan, Coordination of Benefits (COB) will be in effect for any claims incurred by either Spouse and/or any eligible Children. In effect, the Plan will coordinate benefits with itself, so that claims are not paid more than once. However, two Miscellaneous Benefits and Prescription Benefit funds will be available, one for each Participant. Refer to Section 22, Coordination of Benefits and Subrogation.

SECTION 7

BLUE CROSS BENEFIT SUMMARY

The chart below provides a very brief summary of the benefits administered for the Fund by Blue Cross Blue Shield. The coverage percentages are the percentages that Blue Cross Blue Shield will pay of its participating provider approved amount.

Until January 1, 2014, all Members and Children receive the benefits described in the "Enhanced Coverage" column, with no deductible.

Please note that effective January 1, 2014, there are two levels of Blue Cross Blue Shield coverage: "Enhanced Coverage" and "Standard Coverage." Effective January 1, 2017, in order to qualify for Enhanced Coverage for any calendar year, you must complete an annual physical or health maintenance exam during the previous calendar year. In order for the Fund Office to set eligibility for the new year properly, your annual physical or health maintenance exam must be completed by October 31 of the previous year (by October 31, 2017 for the 2018 calendar year). See Section 8, "**Requirements for Obtaining Enhanced Benefit Coverage**" for more details.

A member must complete an annual physical or health maintenance exam during the calendar year in order for the Member and the Member's family to become or remain eligible for Enhanced Coverage. In order for the Fund Office to set eligibility for the new year properly, the annual physical or health maintenance exam must be completed by October 31 of the previous year (by October 31, 2017 for the 2018 calendar year). If you first become eligible during the last six months of the calendar year, you will automatically be placed in Enhanced Coverage for the calendar year following initial eligibility, regardless of whether you have completed the annual physical exam. However, you will be required to meet the annual physical requirement to continue to be eligible for Enhanced coverage in subsequent years.

The annual physical or health maintenance exam referenced in the Plan includes an annual gynecological exam, blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination, health counseling regarding potential risk factors and for Members and Spouses covered under Medicare, the Medicare annual wellness visit.

These benefits are described more fully in Sections 8 and 9 of this Summary Plan Description, and full details are available in the separate Benefit Schedule, which will be provided by the Administrative Manager without cost to any Participant upon request.

For Preventive Care Services, levels of coverage apply where services are provided by in- network service providers (deductibles do not apply).	**Enhanced Coverage***	**Standard Coverage*,****
Routine health maintenance examination in your physician's office-select screening lab procedures including chemical profile, complete blood count or any of its components, urinalysis, chest x-ray, EKG and cholesterol testing – once per calendar year	Covered – 100%	Covered-100%
Gynecological Examination-once per calendar year, no age restrictions	Covered-100%	Covered-100%
Routine Pap smear screening – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Well-baby and child care: • 6 visits, up through 12 months old • 6 visits, 13 months through 23 months old • 6visits, 24 months through 35 months old • 2 visits, 36 months through 47 months old • Visits beyond 47 months are limited to one per member, per calendar year under the health maintenance examination benefit	Covered – 100%	Covered-100%
Immunizations – once per calendar year, no age restrictions	Covered – 100%	Covered-100%

Prostate specific antigen (PSA) screening – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Routine mammography screening – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Flexible sigmoidoscopy exam – once per calendar year, no age restrictions	Covered – 100%	Covered-100%
Fecal occult blood screening-once per calendar year	Covered-100%	Covered-100%
Routine/screening colonoscopy – once per calendar year, no age restrictions; medically necessary colonoscopies are not limited to once per member per calendar year	Covered – 100%	Covered-100%

Physician Office Services

Office, outpatient and home medical visits (non-routine)	Covered – 80% (20% co-pay)	Covered – 100% after $30.00 co-pay
Office consultations	Covered – 80% (20% co-pay)	Covered – 100% after $30.00 co-pay
Urgent care	Covered – 80% (20% co-pay)	Covered – 100% after $30.00 co-pay

Emergency Medical Care

Hospital emergency room (subject to a flat $50.00 co-payment for Enhanced Coverage and a flat $100.00 co-payment for Standard Coverage; co-payment is waived when treatment is received for an accidental injury or when the patient is admitted).	Covered – 100% after $50.00 co-pay	Covered-100% after $100.00 co-pay
Emergency medical care in a physician's office	Covered – 80% (20% co-pay)	Covered -100% after $30.00 co-pay
Ambulance services – medically necessary	Covered – 100%	Covered-80%

Diagnostic Services

Laboratory and pathology services	Covered – 100%	Covered-80%
Diagnostic tests and X-rays	Covered – 100%	Covered-80%
Therapeutic radiology	Covered – 100%	Covered-80%

Maternity Services Provided by a Physician or Certified Nurse Mid-wife

Pre-natal and post-natal care	Covered – 100%	Covered-80%
Delivery and nursery care	Covered – 100%	Covered-80%

Hospital Care

Semi-private room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Non-emergency services must be rendered in a **participating** hospital.	Covered – 100%	Covered-80%
Inpatient consultations	Covered – 100%	Covered-80%
Chemotherapy	Covered – 100%	Covered-80%

Alternatives to Hospital Care

Skilled nursing care and related physician services in a skilled nursing facility, when ordered by the attending physician – limited to 100 days per calendar year	Covered – 80% (20% co-pay) Amounts paid over the covered amount do not count toward the annual out of pocket limit	Covered-80% Amounts paid over the covered amount do not count toward the annual out of pocket limit
Hospice care	Covered – 100%	Covered-80%
Home health care – medically necessary	Covered – 100%	Covered-80%
Home infusion therapy – medically necessary	Covered – 100%	Covered-80%

Surgical Services

Surgery – includes related surgical services	Covered – 100%	Covered-80%
Presurgical consultations (second and third opinions; deductibles do not apply)	Covered – 100%	Covered-80%
Voluntary sterilization (subject to a 90 day waiting period; this waiting period shall not apply to patients who are under age 19)	Covered – 100%	Covered-80%

Human Organ Transplants

Specified human organ transplants – **in designated facilities only**, when coordinated through Blue Cross Blue Shield Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered-80%
Bone marrow transplants – when coordinated through Blue Cross Blue Shield Human Organ Transplant Program (800-242-3504); specific criteria applies	Covered – 100%	Covered-80%
Kidney, cornea and skin transplants	Covered – 100%	Covered-80%

Mental Health Care and Substance Use Disorder Treatment

Inpatient care	Inpatient mental health care	Covered – 100%	Covered-80%
	Inpatient substance use disorder treatment	Covered – 100%	Covered-80%
	Residential substance use disorder treatment	Covered – 100%	Covered-80%
Outpatient mental health care		Covered – 100%	Covered-80%
Outpatient substance use disorder treatment – in approved facilities		Covered – 100%	Covered-80%

Other Covered Services

Outpatient diabetes management program	Covered – 100%	Covered-100%
Allergy testing and therapy	Covered – 80% (20% copay)	Covered-100% after $30.00 co-pay
Chiropractic spinal manipulation – limited to 38 medically necessary visits per calendar year	Covered – 100%	Covered-100% after $30.00 co-pay
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered-80%
Durable medical equipment	Covered – 90% (10% co-pay)	Covered-80%
Non-surgical prosthetic and orthotic devices other than breast prostheses prescribed after cancer surgery, includes orthopedic shoes and non-rigid devices and supplies such as shoe inserts not attached to a medically necessary brace	Covered – 90% (10% co-pay)	Covered-80%

Private duty nursing services	Covered – 90% (10% co-pay) Amounts paid over the covered amount do not count toward the annual out of pocket limit	Covered-80% Amounts paid over the covered amount do not count toward the annual out of pocket limit
Audiometric exam once every 36 months	Covered – 100%	Covered-80%
Hearing aid evaluation test once every 36 months	Covered – 100%	Covered-80%
Ordering and fitting a monaural or binaural hearing aid up to a maximum of $5,000 once every 36 months	Covered – 100%	Covered-80%
Conformity test once every 36 months	Covered – 100%	Covered-80%
Prescription drugs	Not covered	Not covered
Deductible	$100.00 per contract	$250.00 single/$500.00 family
Co-pays	$50 (emergency room visits); 0%, 10% or 20% as noted above	$30.00 or $100.00 as noted above
Co-insurance	None	20%
Lifetime Maximum	None	None

*Enhanced Coverage and Standard Coverage levels apply effective January 1, 2014
**For Standard Coverage, Co-insurance and Deductible are subject to a maximum of $1,250.00 for single coverage and $2,500.00 for family coverage.
NOTE: You must meet your Deductible before we will provide coverage for all services other than preventive care services and presurgical consultations. Deductibles do not apply to preventive care services or presurgical consultations.
***Effective June 1, 2017, the "TrOOP" annual out-of-pocket limit for both Enhanced Coverage and Standard Coverage is $7,150 for single coverage and $14,300 for two person or family coverage. All Deductibles, Co-payment, Co-insurance and other charges for covered services are counted toward the TrOOP out-of-pocket limit, subject to the following exceptions: Amounts paid for premiums, non-covered services, out-of-network balance-billed amounts do not count toward the TrOOP out-of-pocket limit. In addition, for Medicare-Eligible Retirees, prescription medicine expenses do not count toward the TrOOP out-of-pocket limit.
****Coverage for Preventive Care Services are updated automatically at the beginning of each Plan Year for additional benefits as mandated under PPACA. A complete list of these services is located at http://www.uspreventiveservicestaskforce.org.

SECTION 8

HEALTH CARE COVERAGE – BASIC BENEFITS ADMINISTERED BY BLUE CROSS BLUE SHIELD

This portion of the Summary Plan Description provides a brief summary of the coverage provided under the Plan's contract with Blue Cross Blue Shield for health care coverage. It is arranged in the following sub-sections:

- **Requirements for Obtaining Enhanced Coverage**
- **What You Must Pay**
- **Coverage for Hospital, Facility and Alternatives to Hospital Care**
- **Coverage for Physician and Other Professional Provider Services**
- **Coverage for Other Health Care Services**

Requirements for Obtaining Enhanced Coverage

Please note that effective January 1, 2014, there are two levels of Blue Cross Blue Shield coverage: "Enhanced Coverage" and "Standard Coverage." Effective January 1, 2017, in order to obtain Enhanced Coverage for any calendar year, you must complete an annual physical exam or health maintenance exam during the previous calendar year. In order for the Fund Office to set eligibility for the new year properly, the annual physical or health maintenance exam must be completed by October 31 of the previous year (by October 31, 2017 for the 2018 calendar year and so on for each calendar year). You must also provide proof of having done so to the Fund Office by October 31 of the previous calendar year. If you first become eligible during the last six months of the calendar year, you will automatically be placed in Enhanced Coverage and will remain in Enhanced Coverage during the following calendar year regardless of the annual physical requirement. However, you must meet the annual physical requirement in order to remain in Enhanced Coverage in subsequent years.

The annual physical or health maintenance exam referenced in the Plan includes an annual gynecological exam and for Members and Spouses covered under Medicare, the Medicare annual wellness visit.

What You Must Pay

This section explains the Deductible, Co-payments and Co-insurance you must pay each calendar year for health care coverage.

Deductibles, Co-pays and Co-insurance

Your Plan requires you to pay Deductibles and Co-pays. In addition, Standard Coverage requires you to pay "Co-insurance."

Deductible Requirements

A Deductible is an annual amount that you must pay prior to the Plan paying any amount.

If you have Enhanced Coverage, your Deductible is $100.00 per "contract." This means that no matter how many family members are covered through a Member, only one $100 Deductible must be met.

If you have Standard Coverage, your Deductible is $250.00 per individual, maximum $500.00 per family. Deductibles count for determining whether you have met the Standard Coverage out-of-pocket maximum.

Deductibles do not apply to Preventive Care Services (page 71) and do not apply to Pre-surgical Consultations (page 61).

Additional Cost-Sharing For Enhanced Coverage

Under Enhanced Coverage, all additional cost-sharing requirements are called "co-payments" or "co-pays." You must pay a co-pay for the following services:

- $50.00 co-payment for each facility/hospital emergency room visit; the co-payment is waived when treatment is received for an accidental injury or when the patient is admitted.

- All physician visits outside of a hospital have a 20% co- payment, including:
  - Allergy Testing & Therapy Office Outpatient and Home Visits and Office Consultations;
  - Medical Eye Exams (exams due to injury or related to covered medical condition);
  - Emergency Medical Care in a physician's office; and
  - Urgent Care.

- Skilled Nursing Care: 20%

- Private Duty Nursing: 10%

- Prescribed Prosthetic and Orthotic Devices (other than Breast Prostheses following cancer surgery): 10%.

- Durable Medical Equipment (other than diabetes treatment equipment): 10%

There are no Co-payments for covered medical services other than those specified above.

Additional Cost-Sharing For Standard Coverage :

Under Standard Coverage, the flat dollar amounts that you must pay are called "Co-payments" or "Co-pays." **Co-pays do not count towards the Standard Coverage out of pocket/Co-insurance maximum.**

Standard Coverage Co-Payments

You must pay a Co-pay for the following services:

- All physician visits outside of a hospital have a $30.00 Co-payment, including:
  - Allergy Testing & Therapy;
  - Office Outpatient and Home Visits and Office Consultations;
  - Medical Eye Exams (exams due to injury or related to covered medical condition);
  - Emergency Medical Care in a physician's Office;
  - Urgent Care; and
  - Chiropractic Services

Standard Coverage Co-Insurance

The percentage amounts that you must pay are called "Co-insurance." Under Standard Coverage, all services other than covered Preventive Care services, **Specified Human Organ Transplants (page 46), Hospice Care and** Presurgical Consultations and services subject to Co-payments have a 20% Co-insurance requirement.

Standard Coverage Out-of-Pocket Maximum

The Standard Coverage out-of-pocket maximum is the maximum amount of Standard Coverage Deductible and Standard Coverage Co-insurance you can be required to pay per calendar year. Once the Standard Coverage out-of-pocket maximum is met, the services that are otherwise subject to the 20% Co-insurance requirement are paid 100% by the Plan. The maximum amount of out-of-pocket expenses is $1,250 for single coverage and $2,500 for two person or family coverage.

The following out-of-pocket expenses count toward the Standard Coverage out-of-pocket maximum:

- Standard Coverage Deductible (first $250 per individual, $500 per family)
- Standard Coverage Co-insurance (20% of all services other than covered Preventive Care services, Specified Human Organ Transplants, Hospice Care, Presurgical Consultations and services subject to Co-payments)

None of these cost-sharing amounts are eligible for reimbursement under your Miscellaneous Benefit but they may be reimbursed under your Individual HRA.

The following out-of-pocket expenses do not count toward the Standard Coverage out-of-pocket maximum:

- Standard Coverage Co-payments (for example, the $30 Co-payments for physician office visits)
- Prescription Medicine expenses after your $1,440 allowance is used up

True Out-of-Pocket ("TrOOP") Annual Limit

The Affordable Care Act (ACA) requires that all health insurance issuers and group health plans that cover more than one active employee use a uniform maximum for out-of-pocket expenses. The new definition of "out-of-pocket" expenses includes deductibles, coinsurance, and copayments including drugs, office visits, and all other expenses covered but not paid primarily by the plan. Because of this more comprehensive definition, sometimes the ACA out-of-pocket maximum is called a "true" out-of-pocket maximum. To distinguish this from the Standard Coverage out-of-pocket maximum, we will refer to this as the "TrOOP" maximum.

There are a few things that are not included in the out-of-pocket maximum. For example, balance billing amounts for out-of-network providers and expenses for non-covered services are still excluded.

The TrOOP maximum is applied based on the calendar year. It increases at the start of each Plan Year. As of June 1, 2017, the TrOOP for 2017 for the Plan became $7,150 per person, not to exceed $14,300 per family. Once your total out-of-pocket expenses reach this amount, all expenses are paid 100% by the Plan. The TrOOP maximum applies whether you are in the Enhanced Plan or the Standard Plan.

Starting June 1, 2015, if you are not a Medicare-Eligible Retiree (a retiree aged 65 or older), your out-of-pocket expenses for prescription medicines obtained when using your Blue Cross Blue Shield card are counted when determining if you have reached the TrOOP maximum, and if you are not a Medicare-Eligible Retiree, covered prescription medicines obtained when using your Blue Cross Blue Shield card are paid at 100% of the approved amount once you have reached the TrOOP maximum.

If you are a Medicare-Eligible Retiree (a retiree aged 65 or older), your out-of-pocket expenses for prescription medicines are not counted when determining if you have reached the TrOOP maximum, and you will not become eligible for 100% prescription coverage once your Plan TrOOP maximum is reached. The Medicare Retiree Health and Welfare Plan does not include this feature (although cost-sharing for services and covered items other than prescription drugs count toward TrOOP for Medicare-Eligible Retirees). Medicare-Eligible Retirees are encouraged to get Medicare Part D coverage, which has an ever lower Part D TrOOP maximum, after which Medicare pays 100% of prescription drug costs.

Other Limitations On Certain Benefits

Skilled Nursing Maximum Days Per Year

Covered stays in a Skilled Nursing Facility are limited to 100 days per calendar year.

Chiropractic Services

The Plan pays for spinal manipulation to treat misaligned or displaced vertebrae of the spine, with a maximum of 38 visits per Member per year (with a $30.00 per visit co-pay with Standard Benefit Coverage), and one office visit per 12-36 months, depending on the circumstances. See **Chiropractic Services** under **Coverage for Physician and Other Professional Provider Services.**

Hearing Care

We will pay for the audiometric examination, hearing aid evaluation and conformity tests once every 36 months. We will pay for a hearing aid up to a maximum of $5,000 once every 36 months. We will not pay for hearing care services you receive from a Nonparticipating Provider. See **Hearing Care** under **Coverage for Other Health Care Services.**

Waiting Periods

Effective January 1, 2014, there is no waiting period for the treatment of pre-existing conditions.

Coverage For Hospital, Facility And Alternatives To Hospital Care

This section describes the hospital, facility and alternatives to hospital care covered under the Health Care Plan. It includes:

- **Hospital And Facility Care**
  - Inpatient Hospital Services That Are Payable
  - Inpatient Hospital Services That Are Not Payable
  - Hospital Admissions That Are Not Payable
  - Outpatient Hospital Services That Are Payable
  - Outpatient Hospital Services That Are Not Payable
  - Outpatient Mental Health Facility Services
  - Residential and Outpatient Substance Abuse Treatment
  - Freestanding Ambulatory Surgery Facility Services
  - Freestanding Outpatient Physical Therapy Facility Services
  - Freestanding ESRD Facility Services
  - Long-Term Acute Care Hospital Services
- **Alternatives To Hospital Care**
  - Home Health Care Services
  - Home Infusion Therapy
  - Hospice Care Services
  - BlueHealthConnection Program
  - Integrated Case and Disease Management
  - Alternative Facility Services That Are Not Payable
- **How Hospitals, Facilities And Alternative To Hospital Care Providers Are Paid**
  - Participating Providers
  - Nonparticipating Providers

- Emergency Services at a Nonparticipating Hospital
- Emergency Services at a Michigan Nonparticipating Hospital
- Services That You Must Pay
- Out-of-State Providers
- BlueCard Program

Hospital And Facility Care

The services described in this section must be:

- Prescribed by the attending physician, and
- Provided during an inpatient hospital stay or
- Provided in the outpatient department of a hospital or facility
- Hospice Care Services
- For covered services to be payable, they must be medically necessary as defined in Section 25, except as provided in **Coverage for Other Health Care Services** under **"Preventive Care."**

  NOTE: Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting.

Inpatient Hospital Services That Are Payable

- Semiprivate room
- Nursing services
- Meals, including special diets
- Operating room services, including delivery and surgical treatment rooms
- Services provided in a special care unit, such as intensive care
- Anesthetics given by a qualified employee of the hospital
- Diagnostic laboratory and pathology tests/services that are provided under the direction of a pathologist employed by the hospital
- Oxygen and other therapeutic gases and their administration
- Psychological tests directly related to the condition for which the patient is admitted or when such tests have a full role in rehabilitative or psychiatric treatment programs
- Medical supplies such as gauze, cotton, fabrics, plaster and other materials used in dressings and casts
- Cardiac rehabilitation services begun during an admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
- Physical therapy treatment, speech and language pathology services, and occupational therapy used to treat the condition for which the Member is hospitalized, provided the therapy and services meet the requirements described in the Summary Plan Description to be covered.

- Sterilization, whether medically necessary or not. If not medically necessary, a 90-day waiting period applies.

- Prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) that are:

    - Labeled "Rx Only" as defined under the amended Federal Food, Drug and Cosmetic Act and
    - Used during your stay in the hospital
    - Maternity care and routine newborn nursery care during a mother's eligible hospital stay

Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section

However, we may pay for a shorter stay if the attending provider (e.g., your physician or certified nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Also, we may not set the level of benefits or out-of-pocket costs so that any portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain preapproval. Under this Plan, preapproval is generally required only if you enter an inpatient long-term acute care hospital or use a noncontracted hospital under certain circumstances. For information on preapproval, contact your Blue Cross Blue Shield customer service representative.

- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration

- Drugs that are FDA-approved for use in chemotherapy treatment

    NOTE: If the FDA has not approved the drug for the specific disease being treated, Blue Cross Blue Shield's Medical Policy staff determines the appropriateness of the drug for that disease by using the following criteria:

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

- Inhalation therapy

- Electroshock therapy

- Pulmonary function evaluation

- Radioactive isotope studies and use of radium owned or rented by the hospital

- Prosthetic devices permanently implanted in the body or those used externally as part of regular hospital equipment while you are in the hospital (for additional prosthetic and other orthotic benefits)

- External prosthetic and orthotic devices prescribed by a physician for use outside of the hospital

- Cost of obtaining, preserving and storing human skin, bone, blood, and bone marrow to be used for medically necessary covered services

- Hyperbaric oxygenation (therapy given in a pressure chamber)

- Computerized axial tomography, magnetic resonance imaging and positron emission tomography scans provided in participating facilities

- Durable medical equipment:

  - Used in the hospital
  - Rented or purchased from the hospital at the time of discharge

- Cosmetic surgery for:

  - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
  - Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
  - Conditions caused by accidental injuries, and
  - Traumatic scars

  NOTE: Cosmetic surgery and related services are not payable when the services are primarily performed to improve appearance.

- Dialysis services, supplies and equipment to treat:

  - Acute renal (kidney) failure
  - End stage renal disease (ESRD)

    ESRD treatment may also be provided in a participating freestanding facility or in the home (when provided through a program participating with Blue Cross Blue Shield to provide such services).

  NOTE: Dialysis services used primarily to treat ESRD are also covered by Medicare (individuals with ESRD should apply to Medicare).

- Psychiatric day treatment or psychiatric night treatment. We pay for:

  - Services provided by facility staff
  - Ancillary services to patients who are admitted and discharged on the same day of treatment
  - Prescribed drugs given by the hospital in connection with the treatment plan
  - Electroshock therapy when administered by, or under the supervision of, a physician
  - Anesthetics for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy
  - Psychological testing
  - Family counseling

- For patients admitted to a **psychiatric night treatment** facility, we also pay for:

  - A semiprivate room
  - Nursing services
  - Meals, including special diets

- Services performed to obtain, test, store and transplant only the following human tissues and organs:

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

NOTE: We will pay covered services for a donor if the donor does not have transplant benefits under any health care plan.

- Bone Marrow Transplants

  When directly related to up to two single transplants per Member, per condition, we pay for certain services for both allogeneic transplants and autologous transplants for many specific conditions under circumstances specified in detail in the Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

  We do not pay the following for bone marrow transplants:

  - Services that are not medically necessary (see Section 25 for the definition of medical necessity)
  - Services provided by persons or entities that are not legally qualified or licensed to provide such services
  - Services rendered to a donor when the donor's health care coverage will pay for such services
  - Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
  - An autologous tandem transplant for any condition other than germ cell tumors of the testes
  - An allogeneic tandem transplant
  - The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
  - Experimental treatment
  - Any other services or admissions related to any of the above named exclusions

Note that bone marrow transplants are <u>not</u> considered "Specified Human Organ Transplants" as that term is used in this Summary and Plan.

- Specified Human Organ Transplants

  When performed in a designated facility, we pay for transplantation of the following organs, **which are referred to as "Specified Human Organ Transplants:"**

  - Combined small intestine-liver
  - Heart
  - Heart-lung(s)
  - Liver
  - Lobar lung
  - Lung(s)
  - Pancreas
  - Partial liver
  - Simultaneous pancreas-kidney
  - Small intestine (small bowel)

  All payable **Specified Human Organ Transplant** services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the benefit period that begins five days before, and ends one year after, the organ transplant.

  When directly related to the transplant, we pay for specific services and supplies under circumstances specified in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

  <u>Limitations and Exclusions</u>

  During the benefit period, deductibles, co-insurance and co-payments do not apply to the Specified Human Organ Transplants and related procedures.

We do not pay the following for specified human organ transplants:

- Services that are not Blue Cross Blue Shield benefits
- Living donor transplants other than partial liver, lobar lung, and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- 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 surgery and related services performed in a nondesignated facility. You must pay for the transplant surgery and related services you receive in a nondesignated facility.
- Transportation, meals and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered directly related to travel, meals and lodging (examples include, but are not limited to the following: dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, household utilities (including cellular telephones), maids, babysitters or daycare services and entertainment (such as cable television, books, magazines and movie rentals))
- Services prior to your **Specified Human Organ Transplant** surgery, such as expenses for evaluation and testing, unless covered elsewhere under this Summary Plan Description

Experimental transplant procedures. See **Section 9 for guidelines related to experimental treatment**.

Inpatient Hospital Services That Are Not Payable

In addition to the services described as nonpayable throughout the previous subsection, we also do not pay for the following:

- Services that may be medically necessary but can be provided safely in an outpatient or office location
- Services of physicians and surgeons not employed by the hospital (see **Coverage for Physician and Other Professional Provider Services**)
- Custodial care or rest therapy
- Psychological tests if used as part of, or in connection with, vocational guidance training or vocational counseling
- Human organ transplants, except those specifically listed in this Summary Plan Description
- Dental services. However, certain procedures may be payable as medical services if performed in a hospital because the patient has a dental condition that is adversely affecting medical condition under circumstances specified in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request
- Services covered under any other health care benefits plan
- Artificial and endodontic implants and related services, including repair and maintenance of implants and surrounding tissue

Hospital Admissions That Are Not Payable

Hospital admissions that are not covered by your Plan include:

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

- Observation
- Dental treatment, including extraction of teeth, except as otherwise noted in this Summary Plan Description
- Diagnostic evaluations
- Lab exams
- Electrocardiography
- Weight reduction (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
- X-rays, exams or therapy
- Cobalt or ultrasound studies
- Basal metabolism tests
- Convalescence or rest care
- Convenience

- Those mainly for physical therapy, speech and language pathology services or occupational therapy

Outpatient Hospital Services That Are Payable

The services listed under "Inpatient Hospital Services That Are Payable" are also payable when provided as outpatient care (except for those related to inpatient room, board and inhalation therapy). However, the following requirements must also be met when services are provided on an outpatient basis:

- Emergency room services are payable when provided for the initial examination and treatment of medical emergencies or accidental injuries, subject to a $50.00 Co-payment for Enhanced Coverage and a $100.00 Co-payment for Standard Coverage for each facility/hospital emergency room visit. This Co-payment requirement is waived when treatment is received for an accidental injury or when the patient is admitted. However, we do not pay for follow-up care unless covered separately under another provision. In addition, for services received on or before December 31, 2013, benefits obtained from a nonparticipating/nonpanel hospital are limited to $25 per condition.

- Services to treat chronic conditions are payable when they require repeated visits to the hospital.

- Drugs, biologicals and solutions administered in a hospital are payable when they are part of the treatment of the disease, condition or injury.

- Dialysis services (hemodialysis and peritoneal dialysis), supplies and equipment are payable when provided in the home to treat chronic, irreversible kidney failure. Services must be billed by a hospital participating with Blue Cross Blue Shield and must meet the following conditions:

    - The patient’s attending physician and the physician director or a committee of staff physicians of a self-dialysis training program must arrange the treatment.
    - The owner of the patient's home must give the hospital prior written permission to install the equipment.

- We pay for the following dialysis services:

    - Placement and maintenance of a dialysis machine in the patient's home
    - Expenses to train the patient and one other person who will assist the patient in the home in operating the equipment
    - Laboratory tests related to the dialysis
    - Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs
    - Removal of the equipment after it is no longer needed

- The following dialysis services are not payable:

    - Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as "back ups," including hospital personnel sent to the patient's home

- Electricity or water used to operate the dialyzer
- Installation of electric power, a water supply or a sanitary waste disposal system
- Transfer of the dialyzer to another location in the patient's home
- Physician services not paid by the hospital

- Physical therapy, speech and language pathology services and occupational therapy are payable, as described in this Summary Plan Description, when provided for rehabilitation.

- Cardiac rehabilitation services are payable when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required.

Outpatient Hospital Services That Are Not Payable

The services listed under "Inpatient Hospital Services That Are Not Payable" are also not payable when provided as outpatient care. In addition, we do not pay for:

- Outpatient inhalation therapy

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

Outpatient Mental Health Facility Services

Non-participating facility charges are only covered under very limited circumstances. See the Benefit Summary available from the Administrative manager for details.

Outpatient Mental Health Services That Are Payable

- Mental health services provided by a physician or a fully- licensed psychologist (see **Coverage for Physician and Other Professional Provider Services**)

- Services provided 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, a fully-licensed psychologist, or a limited-licensed psychologist when prescribed and billed by a physician or fully-licensed psychologist

Outpatient Mental Health Services That Are Not Payable

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

- Marital counseling

Residential and Outpatient Substance Use Disorder Treatment

Services in residential and outpatient substance use disorder treatment program facilities are payable if the following criteria for the program are met:

- Your physician must:

- Assign a diagnosis of substance use disorder
- Certify whether the treatment required is residential or outpatient
- Provide an initial exam
- Provide and supervise your care during detoxification
- Provide follow-up care during rehabilitation

- The services must be medically necessary for the treatment of your condition

- The services must be approved by Blue Cross Blue Shield and provided by an approved substance use disorder program

Substance Use Disorder Treatment Services That Are Payable

- We pay for the following services provided and billed by an approved substance use disorder treatment program:

  - Lab exams
  - Diagnostic exams
  - Supplies and use of equipment for detoxification or rehabilitation
  - Professional and other trained staff services and program services necessary for care and treatment
  - Individual and group therapy or counseling
  - Counseling for family members
  - Psychological testing
  - Treatment of tobacco dependence

- We also pay for the following in a residential substance use disorder treatment program:

  - Bed and board, including general nursing services
  - Drugs, biologicals and solutions used in the facility

- We also pay for the following in an outpatient substance use disorder treatment program:

  - Drugs, biologicals and solutions used in the program, including drugs taken home

Substance Use Disorder Treatment Services Not Payable

- Services provided primarily for a diagnosis other than substance use disorder

- Dispensing methadone or testing urine specimens, unless you are receiving therapy, counseling or psychological testing

- Diversional therapy

- Services provided beyond the period necessary for care and treatment

- Services provided during the portion of any residential admission that occurs before the effective date of this Plan

- Benefits are payable, up to the limits provided in this Summary Plan Description, for the balance of an admission when coverage under the Plan terminates during the admission

Freestanding Ambulatory Surgery Facility Services

We pay for medically necessary facility services provided by a Blue Cross Blue Shield **participating** ambulatory surgery facility. A patient must be under the care of a licensed doctor of medicine, osteopathy, podiatry or oral

surgery to be admitted to an ambulatory surgery facility. The services must be directly related to performing surgical procedures identified by Blue Cross Blue Shield as covered ambulatory surgery. **A detailed description of the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Freestanding Ambulatory Surgery Facility Services That Are Not Payable

We do not pay for:

- Services by a **nonparticipating** ambulatory surgery facility
- Professional services by a physician. These services, such as surgery, may be covered under **Coverage for Physician and Other Professional Provider Services**

Freestanding Outpatient Physical Therapy Facility Services

We pay our approved amount for services in a freestanding outpatient physical therapy facility only when the facility that provides and bills for them is a **participating** facility.

Freestanding Outpatient Physical Therapy Services That Are Payable

Physical therapy, speech and language pathology services, and occupational therapy, as described in **Coverage for Hospital, Facility and Alternatives to Hospital Care,** are payable when provided for rehabilitation.

Freestanding Outpatient Physical Therapy Services That Are Not Payable

- Services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance use disorder treatment program
- Services provided to you in the home

Freestanding ESRD Facility Services

We pay for medically necessary facility services provided by a Blue Cross Blue Shield **participating** end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney failure. **A detailed description of the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Freestanding ESRD Facility Services That Are Not Payable

- Services provided by a **nonparticipating** end stage renal disease facility
- Services not provided by the employees of the ESRD facility
- Services not related to the dialysis process

Long-Term Acute Care Hospital Services

The services listed under "Inpatient Hospital Services That Are Payable" and "Outpatient Hospital Services That Are Payable" may also be payable when provided in a long-term acute care hospital.

The services are payable only if the following conditions are met:

- The long-term acute care hospital must be located in Michigan and participate with Blue Cross Blue Shield.

- The provider must request and receive preapproval for inpatient services; outpatient services do not require preapproval.

- Long-term acute care hospital services count toward any benefit maximums that apply to inpatient and outpatient hospital services.

We do not pay for:

- Services in a nonparticipating long-term acute care hospital including emergency services

- Inpatient admissions that Blue Cross Blue Shield has not preapproved

- Out-of-state admissions, except with special approval from the Administrative Manager

Alternatives To Hospital Care

Home Health Care Services

This program provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home.

The services described below must be:

- Prescribed by the attending physician

- Provided and billed by a participating home health care agency

- Medically necessary

The following criteria must be met:

- The attending physician certifies that the patient is confined to the home because of illness.

- This means that transporting the patient to a health care facility, physician's office or hospital for care and services would be very difficult due to the nature or degree of the illness.

- The attending physician prescribes home health care services and submits a detailed treatment plan to the home health care agency.

The agency accepts the patient into its program.

A detailed description of the services and supplies that are payable is contained in the detailed benefit schedule. A free copy of the detailed benefit schedule is available from the Administrative Manager on request.

Services That Are Not Payable

- General housekeeping services

- Transportation to and from a hospital or other facility

- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)

- Physician services

- Custodial care or nonskilled care

- Services performed by a nonparticipating home health care provider

Home Infusion Therapy

This program provides coverage for home infusion therapy services whether or not you are confined to the home.

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

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care if the condition can be safely managed in the home

- Medically necessary

- Given by participating home infusion therapy providers

Services include:

- Drugs required for home infusion therapy

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

- Durable medical equipment, medical supplies and solutions needed for home infusion therapy

NOTE: Except for chemotherapeutic drugs, services provided for home infusion therapy under the home health care benefit are not covered separately elsewhere in your Plan.

We do not pay for services rendered by nonparticipating home infusion therapy providers.

Hospice Care Services

We pay for services for the terminally ill provided through a participating hospice program. To be payable, the following criteria must be met:

- The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.

- Certain certifications of terminally ill status are submitted to Blue Cross Blue Shield.

When hospice care is elected, certain home care services or hospice facility services and nursing care, physician services, medical social services, and counseling services become available, and the focus of care shifts primarily to care designed to maintain the comfort of the patient, relieve pain and suffering, and help the patient's family cope with the dying process. **A detailed description of the certifications required and the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

When hospice treatment is elected, the patient or his or her representative must sign a "Waiver of Benefits" form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient's (or family's) understanding that regular Blue Cross Blue Shield benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

NOTE: Blue Cross Blue Shield benefits for conditions <u>not</u> related to the terminal illness remain in effect.

Hospice care services may be canceled at any time by the patient or his or her representative. Simply submit a written statement to the hospice. When the services are canceled, regular coverage under your Plan will be reinstated.

Hospice care services that have been cancelled may be reinstated at any time. The patient is reinstated for any remaining period for which he or she is eligible.

Skilled Nursing Facility Services

We pay for skilled care in a Skilled Nursing Facility when ordered by the attending physician. We may require written confirmation of the need for skilled care from the attending physician. The facility must have a written agreement with Blue Cross Blue Shield to provide benefits under your Plan.

Services That Are Payable

- Payable services are:

  - Semi-private room, general nursing service, meals and special diets;
  - Special treatment rooms;
  - Routine laboratory examinations;
  - Physical, speech, or functional occupational therapy (when medically necessary);
  - Oxygen and other gas therapy;
  - Drugs, biologicals and solutions;
  - Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts;
  - Durable Medical Equipment used in the facility or outside when rented or purchased from the facility upon discharge;
  - Physician services (up to two visits per week).

Services are subject to a 100-day maximum per calendar year. We do not pay for custodial care.

Amounts that you pay for days in excess of the number covered under the Plan do not count toward the annual out-of-pocket maximum.

BlueHealthConnection Program

The BlueHealthConnection Program is a benefit under your Plan. It is an integrated health care management program that assists you in navigating the health care system and provides you with tools and information that you may use to make informed decisions about your health care and treatment options. It gives you access to:

- A nurse call center that is accessible by a toll-free telephone number 24 hours per day, seven days a week – **call 1-800-775-2583**

- Guided self-management tools such as Web-based information and, under certain circumstances, videos and a health directive handbook that allow Members to make decisions about their own health care

- Outreach programs for Members whose claims history indicates that telephone or mail contact with them may assist the Members' understanding and use of services available through BlueHealthConnection

- Integrated case and disease management, described below, for Members with a chronic illness like diabetes or heart disease or acute illness

- The Plan does not cover any services provided under the Provider Delivered Care Management Program under BlueHealthConnection

Integrated Case and Disease Management

Integrated case and disease management is a component of the BlueHealthConnection Program. It is a voluntary program designed to help manage the health care of Members with acute or chronic medical conditions, regardless of the setting. Under integrated case and disease management, we will pay for noncontractual services (services not ordinarily covered by the Plan) only when such services are specifically described in a signed treatment plan that has been approved by Blue Cross Blue Shield and/or the Trustees.

- Services described in the treatment plan will be provided only so long as the plan is in effect.
- Coverage for noncontractual services under integrated case and disease management will only be provided for the specific conditions identified in the treatment plan. Treatment of other conditions remains subject to the terms of your Plan.

Eligibility for Integrated Case and Disease Management

Blue Cross Blue Shield decides who is eligible for integrated case and disease management. Eligibility will be determined with reference to factors such as:

- Candidate's diagnosis
- Admission status
- Clinical status
- Scope of contractual benefits available to the candidate
- Availability of community services to the candidate and his or her family
- Personal and family support available to the candidate
- **Substantial probability of lasting improvement in the candidate's clinical status within 12 months**

Candidates for integrated case and disease management may be identified based on Blue Cross Blue Shield claims data. In addition, we will consider referrals of candidates from such sources as:

- Attending physicians
- Hospitals
- Candidate or candidate's family
- Administrative Manager or Board of Trustees

Termination of Integrated Case and Disease Management

Blue Cross Blue Shield may terminate the treatment plan and the Member's participation in integrated case and disease management if:

- The Member is no longer eligible to receive benefits under this Plan
- The Member voluntarily withdraws from the program

- The Member meets the treatment plan goals. (Termination in these cases occurs when the case manager determines that the goals have been met. As a result, termination may occur well before any expiration period described in the treatment plan is reached.)

- The Member fails to meet the treatment plan goals within the time period specified in the treatment plan

- The time period described in the Member's treatment plan expires

- The Member (or his or her representative), treating physician or case manager determines that the Member's participation in case management will no longer result in measurable improvement in the Member's clinical status

Services That Are Not Payable

We do not pay for any services provided by a relative of the Member.

Denials of claims for Integrated Case and Disease Management by Blue Cross Blue Shield can be appealed to the Board of Trustees. See **Filing Claims and Appeals.**

Alternative Facility Services That Are Not Payable

We do not pay for any services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.

How Hospitals, Facilities And Alternative To Hospital Care Providers Are Paid

Participating Providers

Almost all Michigan hospitals and many alternatives to hospital care providers participate with your Plan. Sometimes providers outside of Michigan participate with your Plan. The provider sends the claims to Blue Cross Blue Shield. Blue Cross Blue Shield will pay the approved amount directly to the provider.

- The provider accepts our payment as payment in full, less any Co-payments (and/or Co-insurance under Standard Coverage) or Deductible you are required to pay.

- You do not need to pay any amount beyond Co-payments (and/or Co-insurance under Standard Coverage) that apply to medically necessary services covered by your Plan (except in the limited cases described below).

- Even if the participating provider's charge for a covered service is more than our payment, you will not need to pay the difference.

- A participating provider has agreed not to charge you for services not covered by your Plan, if Blue Cross Blue Shield determines the service is not medically necessary (this determination is made through Blue Cross Blue Shield's audit process).

If you need to know if a provider participates, ask your doctor, the provider's admitting staff, or call your local customer service representative. (Use the numbers listed in the "How to Reach Blue Cross Blue Shield " section at the end of this SPD.) A copy of the listing of participating providers is provided automatically to each Member with this Summary Plan Description, at no charge, and additional free copies are available upon request.

Nonparticipating Providers

If you go to a nonparticipating hospital, facility or alternative to hospital care provider, you will need to pay most of the charges yourself. Your bill could be substantial. To receive payment for covered services (less any Co-payments (and/or co-insurance under Standard Coverage) you are required to pay) you will need to send Blue Cross Blue Shield a claim.

Nonparticipating provider charges are eligible for reimbursement from the Miscellaneous Benefit and the Individual HRA Plan. **Note that if you use your Benefit Advisor Card to pay a non-participating provider, your Individual HRA Account will be used to pay the bill. The only way to use Miscellaneous Benefits for a non-participating provider is to manually submit your claim to the Fund Office.**

(Call your customer service representative for information on filing claims. See **How to Reach Blue Cross Blue Shield**.)

- **The Plan does not pay for services provided by any of the following providers when they are nonparticipating providers:**

  - outpatient physical therapy facilities,
  - freestanding ambulatory surgery facilities,
  - skilled nursing facilities,
  - hospice programs,
  - long-term acute care facilities,
  - home health care agencies, or
  - home infusion therapy providers.

Except as provided below **Blue Cross Blue Shield coverage at other nonparticipating hospitals and facilities, both in and out of Michigan, is limited to services needed to treat an accidental injury or medical emergency.** We do not pay for nonemergency services in a nonparticipating hospital or facility, except as provided in this Section. The following explains your coverage when provided by a nonparticipating hospital or facility.

Emergency Services at a Nonparticipating Hospital

We will pay our approved amount, less any Co-payment you are required to pay under the Plan, for **emergency services** provided by an **accredited nonparticipating hospital or facility:**

- Located in an area not served by another Blue Cross and/or Blue Shield Plan; or

- Located in Michigan but not participating with another Blue Cross and/or Blue Shield Plan; or

- Participating with another Blue Cross and/or Blue Shield Plan, regardless of the facility's location.

Services That You Must Pay

You are required to pay for the following services:

- Services that are not included in your Plan

- Services that are not medically necessary **if** you agree to receive them after being advised by hospital staff that they will not be covered and you agree in advance **and** in writing to pay for them

In some cases, you **are required** to pay for services that **are medically necessary**. These limited cases are:

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

- When you fail to provide the hospital with information to identify your coverage

Out-of-State Providers

- An out-of-state provider may require you to pay for services at the time they are provided. If so, submit an itemized statement to Blue Cross Blue Shield for the services. Blue Cross Blue Shield will pay the approved amount to you.

- An out-of-state provider may submit a claim. If so, Blue Cross Blue Shield will pay the approved amount to the provider.

BlueCard Program

Blue Cross Blue Shield has arrangements with certain Blue Cross Blue Shield systems in other states that allow you to receive covered services when you are outside of Blue Cross Blue Shield's coverage area. This is called the **BlueCard Program**. If you receive covered services in another state from a BlueCard participating provider, the Host Plan will pay the provider the amount required under its contract with the provider less any Deductible, Co-payment or Co-insurance required under your Plan. After the Host Plan pays the provider, Blue Cross Blue Shield reimburses the Host Plan the amount required under the BlueCard Program.

If the provider is not a BlueCard participating provider, we will pay for out-of-state services as described above.

Your deductible, co-payment and co-insurance for services received outside of Michigan will be calculated using the designated payment level.

NOTE: Your deductible, co-payment and co-insurance requirements are based on your Plan and remain the same regardless of which Host Plan processes your claim for services.

The BlueCard Program will not apply if:

- The services are not a benefit under your Plan

- The Plan excludes coverage for services performed outside of Michigan or

- The services are performed by a vendor or provider who has a contract with Blue Cross Blue Shield for those services

Special Temporary Nonparticipating Hospital Coverage

If a participating hospital terminates its participating contract with Blue Cross Blue Shield, members may have difficulty obtaining certain services from participating hospitals. Under limited circumstances, the Plan provides temporary benefits for designated services, emergency care, and travel, meals, and lodging as described below from certain out-of-area hospitals and noncontracted area hospitals that are not participating hospitals. **These temporary benefits are provided only for certain specified services and only during the six-month period following the date a noncontracted area hospital terminated its participating contract with Blue Cross Blue Shield.**

A detailed description of the services and supplies that are payable under these circumstances is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Preapproval of special temporary nonparticipating hospital coverage services (except emergency care or ambulance services) must be obtained from Blue Cross Blue Shield before we will consider them for payment. If the required preapproval is not obtained, you must pay for these services.

Blue Cross Blue Shield customer service representatives can provide you and your physician with the telephone number to call for preapproval (see the **How to Reach Blue Cross Blue Shield** section at the end of this SPD). If the request for preapproval relates to a bone marrow transplant or an organ transplant, please ask your customer service representative for the telephone number of the Human Organ Transplant Program.

NOTE: Preapproval of services is not a guarantee that a claim for them will be paid. All claims are subject to a review of the reported diagnosis, medical necessity verification, the availability of benefits at the time the claim is processed as well as the requirements, conditions, limitations, exclusions, maximums, Deductibles, Co-payments and Co-insurance under your Plan.

Preapproval of special temporary nonparticipating hospital coverage services must be obtained as follows:

- Designated Services

Designated services are services that Blue Cross Blue Shield determines only a noncontracted area hospital can provide. Your physician must obtain preapproval for designated services by calling Blue Cross Blue Shield. If preapproval is not obtained, the designated services you receive will not be covered and you will be responsible for the hospital's charges.

- Travel, Meals and Lodging

You must obtain preapproval for any travel, meals and lodging expenses before they are incurred. If you do not obtain preapproval, travel, meals and lodging will not be covered and you will be responsible for these costs. Please call Blue Cross Blue Shield to obtain preapproval.

When Special Temporary Nonparticipating Hospital Coverage Benefits End

The benefits for special temporary nonparticipating hospital coverage are temporary. They will end six months from the date a noncontracted hospital terminated its participating contract with Blue Cross Blue Shield.

Coverage For Physician And Other Professional Provider Services

This section describes physician and other professional provider services covered by your Plan. It tells you:

- **Physician** And **Other Professional Provider Services That Are Payable**
- **Physician And Other Professional Provider Services That Are Not Payable**
- **How Physician And Other Professional Provider Services Are Paid**
- **Participating Providers**
- **Nonparticipating Providers**
- **Out-of-State Providers**
- **BlueCard Program**

Physician And Other Professional Provider Services That Are Payable

Except as provided under "Preventive Care," in order to be paid, services must be medically necessary and provided by persons who are legally qualified or licensed to provide them.

- **We pay our approved amount for the services described in this section (cost-sharing information is in "What You Must Pay"). These pages explain the extent to which the service is covered.**

    - Surgery
    - Presurgical Consultation
    - Anesthetics
    - Technical Surgical Assistance
    - Obstetrics
    - Newborn Examination
    - Inpatient Medical Care
    - Inpatient Mental Health Care
    - Outpatient Mental Health Care
    - Residential and Outpatient Substance Use Disorder Treatment
    - Inpatient Consultations
    - Emergency Treatment
    - Chemotherapy
    - End Stage Renal Disease (ESRD)
    - Therapeutic Radiology
    - Diagnostic Radiology
    - Diagnostic Services
    - Diagnostic Laboratory and Pathology Services
    - Allergy Testing and Therapy
    - Chiropractic Services
    - Physical, Speech and Language Pathology and Occupational Therapy Services
    - Office, Outpatient and Home Medical Care Visit
    - Cardiac Rehabilitation
    - Optometrist Services

Surgery

- Payment includes:

    - Physician's surgical fee
    - Medical care provided by the surgeon before and after surgery while the patient is in the hospital
    - Visits to the attending physician for the usual care before and after surgery

Multiple Surgeries

Multiple surgeries performed on the same day by the same physician are paid according to national standards recognized by Blue Cross Blue Shield.

Restrictions

- Dental surgery is payable **only** under limited circumstances stated in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.

- Surgery for gender reassignment is payable **only** for reconstructive procedures of the genitalia. Surgical procedures involving the face, vocal cords, breasts, abdomen, hips or other nongenital areas are not payable.

- Cosmetic surgery is payable **only** for:

    - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
    - Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
    - Conditions caused by accidental injuries
    - Traumatic scars

NOTE: Physician services for cosmetic surgery are **not payable** when services are primarily performed to improve appearance.

Presurgical Consultation

When your physician recommends surgery, you have the option of having a presurgical consultation with another physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon**.

You may obtain presurgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under your Plan.

You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:

- Second opinion - a consultation to confirm the need for surgery
- Third opinion - allowed if the second opinion differs from the initial proposal for surgery
- Nonsurgical opinion - given to determine your medical tolerance for the proposed surgery

Deductibles, Co-payments and Co-insurance required under your Plan do not apply to any of the three presurgical consultations listed above if they are obtained from participating physicians.

Anesthetics

For surgery

Services for giving anesthetics to patients undergoing covered surgery are payable to either:

- A physician other than the operating physician
- A physician who orders and supervises anesthesiology services
- A certified registered nurse anesthetist (CRNA) in an
    - Inpatient hospital setting
    - Outpatient hospital setting
    - Participating ambulatory surgery facility

CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

If the operating physician gives the anesthetics, the service is included in our payment for the surgery.

NOTE: Anesthesiology services performed by a qualified employee of a hospital or facility are not covered in this section of the Summary Plan Description. (See **Inpatient Hospital Services That Are Payable**.)

For infusion therapy

We pay for local anesthetics only when needed as part of infusion therapy done in the physician's office.

Technical Surgical Assistance (TSA)

In some cases, an additional physician provides technical assistance to the surgeon. We pay the approved amount for TSA, provided according to Blue Cross Blue Shield guidelines, in a hospital inpatient or outpatient setting or in an ambulatory surgery facility. A list of covered TSA surgeries is available from your local customer service center.

We do not pay for TSA:

- When services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
- When services are provided in a location other than a hospital or ambulatory surgery facility

Obstetrics

Prenatal and postnatal services are payable, as are services provided by the physician attending the birth.

Certified Nurse Midwife

We pay the approved amount for the following services when provided by a Certified Nurse Midwife minus any applicable Co-payments:

- Normal vaginal delivery when provided in:
  - an inpatient hospital setting
  - a birthing center which is hospital affiliated, state licensed and accredited as defined and approved by Blue Cross Blue Shield.
- Pre-natal care
- Post-natal care, including a Papanicolau (PAP) smear during the six-week visit.

Newborn Examination

A newborn's first routine physical exam is payable when provided during the mother's inpatient hospital stay. A doctor other than the anesthesiologist or the mother's attending physician must provide the exam.

NOTE: The baby must be eligible for coverage and must be added to your contract within 30 days of the birth. Ask the Fund Office or call Blue Cross Blue Shield.

Inpatient Medical Care

We pay for medical care by your attending physician while you are receiving inpatient services.

Inpatient Mental Health Care

We pay for the following inpatient mental health services when provided by a physician:

- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Psychological testing

- Electroshock therapy and its related anesthetics

- Inpatient consultations when your physician requires assistance in diagnosing or treating your mental health condition, when the assistance is required because of the special skill or knowledge of the consulting psychologist.

The following are covered for inpatient services performed by fully licensed psychologists with hospital privileges:

- Psychological testing

- Individual psychotherapeutic treatment

- Family counseling for members of a patient's family

- Group psychotherapeutic treatment

- Inpatient consultations when your physician requires assistance in diagnosing or treating your mental health condition, when the assistance is required because of the special skill or knowledge of the consulting psychologist

We do not pay for:

- Staff consultations required by a facility or program's rules

- Marital counseling (although family counseling for a spouse of a patient is covered)

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

Outpatient Mental Health Care

Unless otherwise specified, we pay for the outpatient mental health services listed below when provided by a physician or fully-licensed psychologist in an office setting or in a participating outpatient mental health facility. (See **Outpatient Mental Health Facility Services** in **Coverage for Hospital, Facility and Alternatives to Hospital Care** for a description of when these services are payable.)

- Individual psychotherapeutic treatment of less than 20 minutes provided in a participating outpatient mental health facility

- Individual psychotherapeutic treatment of more than 20 minutes

- Family counseling for members of a patient's family

- Group psychotherapeutic treatment

- Psychological testing by:

    - A physician or a fully-licensed psychologist or
    - A limited-licensed psychologist when prescribed and performed under, and billed by, a physician or fully-licensed psychologist

We do not pay for:

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

- Services provided to an inpatient in a hospital, skilled nursing facility or residential substance use disorder treatment program, except as provided below.

- Marital counseling (but family counseling for the spouse of a patient is covered)

Residential and Outpatient Substance Use Disorder Treatment

We pay the approved amount for medical care by a physician for treatment of substance use disorder in residential and outpatient substance use disorder treatment programs.

We pay for the assistance of a consulting physician when you are in an approved residential substance use disorder treatment program if the physician in charge of your case requests the assistance because special skill or knowledge is required to diagnose or treat the condition.

We do not pay staff consultations required by a facility or program’s rules.

Inpatient Consultations

Inpatient consultations are payable when your physician requires assistance in diagnosing or treating your condition, if the assistance is required because of the special skill or knowledge of the consulting physician or professional provider.

NOTE: Outpatient and office consultations are payable as office visits.

We do not pay for staff consultations required by a facility or program's rules.

Emergency Treatment

Services of one or more physicians for the initial exam and treatment of a medical emergency or an accidental injury are payable. Follow-up care is not considered emergency treatment.

Chemotherapy

We pay our approved amount for chemotherapeutic drugs. To be payable the drugs must be:

- Ordered by a physician for the treatment of a specific type of malignant disease

- Provided as part of a chemotherapy program

- Approved by the Food and Drug Administration (FDA) for use in chemotherapy treatment

  NOTE: If the FDA has not approved the drug for the specific disease being treated, Blue Cross Blue Shield's Medical Policy staff determines the appropriateness of the drug for that disease by using the following criteria:

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

  We also pay for:

- Physician services to administer the chemotherapy drug, **except** those taken orally

- The chemotherapy drug administered in a medically approved manner

- Other FDA-approved drugs classified as:

    - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
    - Drugs used to enhance chemotherapeutic drugs
    - Drugs to prevent or treat the side effects of chemotherapy treatment

- Administration sets, refills and maintenance of implantable or portable pumps and ports

End Stage Renal Disease (ESRD)

Physician services are payable for the treatment of ESRD. Services may be provided in the hospital, a participating freestanding ESRD facility or in the home.

NOTE: Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration. **A detailed description of the services and supplies that are payable for ESRD is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Therapeutic Radiology

We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by the attending physician or by another physician, if prescribed by the attending physician.

Diagnostic Radiology

We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- X-rays

- Ultrasound

- Radioactive isotopes

- Computerized axial tomography (CAT) scans

- Magnetic resonance imaging (MRI) for specific diagnoses

- Positron emission tomography (PET) scans

NOTE: You may call Blue Cross Blue Shield for information about any restrictions.

The services must be provided by your physician or by another physician if prescribed by your physician.

NOTE: Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities. You or your physician may call us for a list of participating facilities.

We do not pay for:

- Miniature X-ray plates, chest fluoroscopies, screening services (except routine mammograms)

- Procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury except as provided under **Preventive Care** in **Coverage for Other Health Care Services.**

Diagnostic Services

We pay for diagnostic services used by a physician to diagnose disease, illness, pregnancy or injury.

- Physician services are payable for tests such as:
  - Thyroid function
  - Electrocardiogram (EKG)
  - Electroencephalogram (EEG)
  - Pulmonary function studies

- Physician and independent physical therapist services are payable for the following tests:
  - Electromyogram (EMG)
  - Nerve conduction

- We pay for EMG and nerve conduction tests performed by an independent physical therapist if ordered by a physician. The independent physical therapist must be certified by the American Board of Physical Therapy Specialties to perform these tests.

Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology services needed to diagnose a disease, illness, pregnancy or injury. In addition, we pay for laboratory and pathology services as provided under **Preventive Care** in **Coverage for Other Health Care Services.** The services must be provided by your physician or by another physician if prescribed by your physician.

- Standard office laboratory tests are payable when performed in a physician's office in connection with the medical care given at the time of the visit.

- Standard laboratory tests are tests that:
  - Blue Cross Blue Shield has identified as payable and
  - Are essential to the patient's care at the time of the visit (also referred to as "immediate results" tests)

- Non-standard laboratory tests (tests that Blue Cross Blue Shield has identified as payable and are not essential to the patient's care at the time of the visit) are payable only when prescribed by a physician and performed by an independent laboratory or outpatient hospital laboratory

Allergy Testing and Therapy

We pay for the following allergy testing and therapy services, performed by, or under the supervision of, a physician:

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

- Your Plan requires a 20 percent Co-payment for allergy testing and therapy.

We do not pay for:

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

Chiropractic Services

We pay for the following chiropractic spinal manipulative treatment (with a $30.00 co-pay per visit for Standard Coverage):

- Spinal manipulation to treat misaligned or displaced vertebrae of the spine, with a maximum of 38 visits per Member per year.
- Office visits:
  - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received services within 36 months.
  - For established patients, we pay for one office visit per year. An established patient is one who has received services within 36 months.
- Mechanical traction once per day when it is performed with chiropractic spinal manipulation.
- Radiological services when X-rays are medically necessary to treat the spinal misalignment

Physical, Speech and Language Pathology and Occupational Therapy Services

We pay for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation. These services must be prescribed and provided by the appropriate providers, and must be likely to result in specific improvement of the patient's condition.

A detailed description of the types of providers that are payable, the conditions that must be met, and the services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Office, Outpatient and Home Medical Care Visits

We pay for office visits (including office consultations), outpatient and home medical care visits, therapeutic injections by a physician, medical eye exams, emergency care in a physician's office and urgent care. The services must be to examine, diagnose and treat any condition of disease, pregnancy (including prenatal and postnatal care) or injury, except as provided in **Preventive Care** under **Coverage for Other Health Care Services.**

NOTE: Under Enhanced Coverage, your Plan requires a 20 percent Co-payment for these services. Under Standard Coverage, your Plan requires a $30 per visit Co-pay for these services. You are not required to pay a Co-payment for presurgical consultations.

We do not pay for:

- Routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy, or injury, and except as provided in **Hearing Care** under **Coverage for Other Health Care Services.**

Certified Nurse Practitioner

We pay for covered services performed by a certified nurse practitioner when the services are provided in any location, except a hospital inpatient setting.

NOTE: Certified nurse practitioner services are payable subject to the Co-payment requirements for office visits (including office consultations), outpatient and home medical care visits, therapeutic injections, medical eye exams, emergency care in a physician's office and urgent care.

Cardiac Rehabilitation

We pay for intensive monitoring (EKGs) and/or supervision during exercise in a physician-directed clinic (one in which a physician is on-site).

Optometrist Services

We pay our approved amount for covered services performed by a licensed optometrist within the scope of his or her license.

- The medical and surgical services performed by the optometrist must be provided within the state of Michigan.
- The optometrist must be licensed in the state of Michigan and certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents.
- Services performed by the optometrist will be considered services obtained from a nonparticipating provider if the optometrist does not participate under Blue Cross Blue Shield's vision program.

We do not pay for routine eye refractions, **except** in connection with a medical diagnosis, pregnancy, or injury.

Physician and Other Provider Services That Are NOT Payable

We do not pay for the following services:

- Services covered under any other Blue Cross or Blue Shield plan or under any other health care benefits plan
- Screening services, except as provided in **Preventive Care** under **Coverage for Other Health Care Services.**
- Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed in **Surgery**, above.
- Health care services provided by persons who are not legally qualified or licensed to provide them
- Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization)
- Weight loss programs (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
- Prescription medicines provided by a pharmacy; see Section 10 for your separate non-Blue Cross Blue Shield Prescription Medicine Benefits
- Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

- Services, care, supplies or devices not prescribed by a physician
- Services provided during nonemergency medical transport
- Experimental treatment
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Hearing aids or services to examine, prepare, fit or obtain hearing aids except as provided in **Hearing Care** under **Coverage for Other Health Care Services**.
- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
- Hospital services, including services provided by hospital employees, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.
- Drugs, medical appliances, materials or supplies and blood transfusions, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.
- Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, **except** as provided in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.
- Self-treatment by a professional provider and services given to parents, siblings, spouse or children
- Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
- Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient’s endurance while exercising and management of risk factors are stable
- Infertility services that do not treat a medical condition, other than infertility. This can include services such as:
    - Sperm washing
    - Post-coital test
    - Monitoring of ovarian response to ovulatory stimulants
    - In vitro fertilization
    - Ovarian wedge resection or ovarian drilling
    - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
    - Diagnostic studies done for the sole purpose of infertility assessment
    - Any procedure done to enhance reproductive capacity or fertility
- The following services provided by a Certified Nurse Practitioner that are:
    - not covered by your Plan
    - performed when you are a hospital inpatient

  NOTE: You or your physician can call Blue Cross Blue Shield to determine if other proposed services are not covered benefits under your Plan.

How Physician And Other Professional Provider Services Are Paid

We pay the approved amount (reduced by your Co-payment (or Co-insurance under Standard Coverage)) for each medically necessary covered service. In addition, as provided in Preventive Care under Coverage for Other Health Care Services, we pay the approved amount for certain preventive care services.

Participating Providers

- The participating provider submits a claim to us for the services you receive.
- We pay the provider directly for the covered services.

A participating provider may bill you when:

- You receive a service not covered by your Plan
- You acknowledge that we will not pay for medically unnecessary services and you agree, in writing, before receiving the services, that you will pay
- We deny a claim from a participating provider that was submitted more than 180 days after the service because you did not furnish needed information

Nonparticipating Providers

You should expect to pay charges to a nonparticipating provider at the time you receive the services. You should then submit a claim to Blue Cross Blue Shield. If Blue Cross Blue Shield approves the claim, it will send payment to you.

Nonparticipating provider charges are eligible for reimbursement from the Miscellaneous Benefit and the Individual HRA Plan. **Note that if you use your Benefit Advisor Card to pay a non-participating provider, your Individual HRA will be used to pay the bill. The only way to use Miscellaneous Benefits for a non-participating provider is to manually submit your claim to the Fund Office.**

NOTE: Because nonparticipating providers often charge more than our maximum payment level, Blue Cross Blue Shield's payment may be less than the amount charged by the provider.

Nonparticipating providers, except independent physical therapists, **may** agree to participate on a per claim basis. This means that they will accept the approved amount as payment in full for a specific service. If so:

- The provider will submit a claim to Blue Cross Blue Shield
- Blue Cross Blue Shield will send payment to the nonparticipating provider

Out-of-State Providers

- An out-of-state provider may require you to pay for services at the time they are provided. If so, submit an itemized statement to Blue Cross Blue Shield for the services. Blue Cross Blue Shield will pay the approved amount to you.
- An out-of-state provider may submit a claim. If so, Blue Cross Blue Shield will pay the approved amount to the provider.

BlueCard Program

Blue Cross Blue Shield has arrangements with certain Blue Cross Blue Shield systems in other states that allow you to receive covered services when you are outside of Blue Cross Blue Shield's coverage area. This is called the BlueCard Program. If you receive covered services in another state from a BlueCard participating provider, the Host Plan will pay the provider the amount required under its contract with the provider less any Deductible, Co-payment or Co-insurance required under your Plan. After the Host Plan pays the provider, Blue Cross Blue Shield reimburses the Host Plan the amount required under the BlueCard Program.

If the provider is not a BlueCard participating provider, Blue Cross Blue Shield will pay for out-of-state services as described above.

If your Plan requires a Deductible, Co-payment, or Co-insurance, your payment for services received outside of Michigan will be calculated using the designated payment level.

NOTE: Your Deductible, Co-payment and Co-insurance requirements are based on your Plan and remain the same regardless of which Host Plan processes your claim for services.

The BlueCard Program will not apply if:

- The services are not a benefit under your Plan
- Your Plan excludes coverage for services performed outside of Michigan or
- The services are performed by a vendor or provider who has a contract with Blue Cross Blue Shield for those services

Coverage For Other Health Care Services

This section describes coverage for other health care services. The facility and professional services listed below are paid as described in "Coverage for Hospital, Facility and Alternatives to Hospital Care" and "Coverage for Physician and Other Professional Provider Services."

Preventive Care Services

Your Plan provides coverage for the following preventive care/screening services once per calendar year up to the Blue Cross Blue Shield approved amount without age limitation, with no Deductibles, Co-payments or Co-insurance:

- **Health Maintenance Exam**

This is a comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

- **Gynecological Examination**

Screening for Routine Laboratory and Radiology Services includes chemical profile, complete blood count or any of its components, urinalysis, chest x-ray, EKG and cholesterol testing

- **Immunizations**
- **Well-Baby/Well-Child Care Visits and Immunizations**

These are included within and not in addition to the annual Health Maintenance Exam indicated above as follows:

- 6 visits from birth through 12 months;
- 6 visits from 13- months through 23 months ;6 visits from 24 months through 35 months ;
- 2 visits from 36 months through 47 months ; and
- 1 visit beyond 47months under the health maintenance exam benefit

- **Prostate Specific Antigen (PSA) Test**
- **Mammogram**
- **Pap Smear and related Laboratory and Pathology Services**
- **Fecal Occult Blood Screening**
- **Flexible Sigmoidoscopy Exam**
- **Colonoscopy**

- Any medical Preventive Care Services mandated by PPACA and added effective the first day of the Plan Year based on the updated list of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and that are listed at http://www.uspreventiveservicestaskforce.org;

- Immunizations mandated by PPACA and added effective the first day of the Plan Year that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved that are listed at http://www.cdc.gov/vaccines/schedules/hcp/adult.html and http://www.cdc.gov/vaccines/hcp/child-adolescent.html;

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings mandated by PPACA and added effective the first day of the Plan Year that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and that are listed at http://www.uspreventiveservicestaskforce.org;

- With respect to women, such additional preventive care and screenings mandated by PPACA and added effective the first day of the Plan Year as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and that are listed at http://www.hrsa.gov/womenguidelines/.

Dental Care and Dental Appliances

This section describes dental care covered by the Basic Benefits part of your coverage. See **Section 23 for Delta Dental administered dental coverage**.

Emergency Dental Treatment

We pay our approved amount for treatment of accidental injuries. An accidental injury is defined as occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

We pay for emergency treatment within 24 hours of the accidental injury to relieve pain and discomfort.

We must preapprove any follow-up services**.** You must complete follow-up treatment within six months of the accidental injury unless Blue Cross Blue Shield determines that the Member's condition makes treatment within this time period impossible.

We do not pay for:

- Treatment that was previously paid as a result of an accident

- Through December 31, 2013, dental conditions existing before the accident; however, this provision does not apply to a pre-existing accidental injury to a patient if the treatment of the pre-existing accidental injury satisfies the emergency treatment and follow-up treatment requirements stated above.

- Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue

Services to treat temporomandibular joint dysfunction, except as provided in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.

Durable Medical Equipment

We pay Blue Cross Blue Shield's approved amount for rental or purchase of durable medical equipment when prescribed by a physician. This coverage is subject to a 10% co-payment with Enhanced Coverage and 20% co-insurance with Standard Coverage. We cover the same items covered by the Medicare Part B Program when the items meet the following guidelines:

- The prescription includes a description of the equipment and the reason for the need or the diagnosis.

- The physician writes a new prescription when the current prescription expires; otherwise, the Plan will stop payment on the current expiration date or 30 days after the date of the patient's death, whichever is earlier.

- The co-payment and co-insurance requirements do not apply to insulin pumps and related supplies.

NOTE: If the equipment is:

- Rented, we do not pay for the charges that exceed the purchase price

- Purchased, we will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

We do not pay for:

- Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats

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

- Comfort and convenience items, such as bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners

- Physician's equipment, such as stethoscopes

- Self-help devices not primarily medical in nature, such as sauna baths and elevators

- Experimental equipment

Prosthetic and Orthotic Devices

The Plan pays Blue Cross Blue Shield's approved amount for prosthetic and orthotic devices prescribed by a physician. This includes the cost of purchasing, replacing, obtaining, developing and fitting the basic device and any medically necessary special features. Repairs, limited to the cost of a new device, are also covered. The prescription must include a description of the equipment and the reason for the need or the diagnosis.

We generally cover external prosthetic and orthotic devices that are considered payable by Medicare Part B as of the date of purchase or rental.

In addition, we cover orthopedic shoes that are not attached to a medically necessary brace and non-rigid devices and supplies such as shoe inserts and supportive appliances for the feet that are not attached to a medically necessary brace.

To be covered, custom-made devices must be furnished by a provider that is fully accredited or, with Blue Cross Blue Shield approval, conditionally accredited by the American Board of Certification in Orthotics and Prosthetics, Inc. (ABC), or, with Blue Cross Blue Shield approval, a provider who is either an MD, DO, Orthopedist, Prosthetic provider, Doctor of Podiatric Medicine (DPM), or durable medical equipment (DME) provider. You can call Blue Cross Blue Shield to confirm a provider's status.

Devices and Services That Are Not Payable

Some prosthetic and orthotic devices and services are not covered under your Plan. These include:

- Spare prosthetic devices
- Routine maintenance of the prosthetic device
- Prosthetic devices that are experimental
- Hair prostheses such as wigs, hairpieces, hair implants, etc.

A more detailed description of the orthotic and prosthetic services and supplies that are payable is contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Hearing Care

Covered Services

Your Plan pays the approved amount to **participating providers** for:

- An audiometric examination that is performed by a participating physician-specialist, audiologist, or hearing aid dealer
- A hearing aid evaluation test and a conformity test prescribed by a physician and performed by a participating physician-specialist, audiologist, or hearing aid dealer
- A monaural or binaural hearing aid that meets Blue Cross Blue Shield requirements.

Limitations and Exclusions

We will pay for the audiometric examination, hearing aid evaluation, conformity tests and a hearing aid once every 36 months, up to a maximum of $5,000 for the hearing aid. We will consider providing additional hearing care benefits if a physician-specialist sends Blue Cross Blue Shield documentation of severe hearing loss that has occurred within 36 months. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

The Plan generally pays these covered services **only when obtained from participating providers. The Plan will not pay for hearing care services if they are provided by a Nonparticipating Provider.**

You must obtain a medical evaluation (sometimes called a medical clearance examination) performed by a physician-specialist before you receive your hearing aid.

Details of the hearing care services and supplies that are payable and additional restrictions and requirements are contained in the detailed Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.

Medical Supplies

We pay for medical supplies and dressings to be used in your home for the treatment of a specific medical condition. We do not pay for prescription medications used outside of the hospital. See **Section 10, Miscellaneous Benefits and Prescription Medicine Benefits**, for the prescription medicine allowance administered by the Fund Office.

Medicare Supplemental Benefits

The Plan provides benefits for Members enrolled in Medicare for services that are normally covered by the Plan.

If the covered services are provided by a Medicare participating provider or another provider that has agreed to accept the Medicare approved amount as full payment, the Plan will pay the deductible and the co-insurance amounts required by Medicare minus any Deductible, Co-payment or Co-insurance that would be required under the Plan for the covered services. For these claims, the Plan and Medicare pay the provider.

For claims for services for which the provider has not agreed to accept the Medicare approved amount as payment in full, the Plan's payment will be based on the Medicare approved amount, or the Blue Cross Blue Shield approved amount, whichever is greater, minus the Medicare payment, and minus any applicable Deductible, Co-payment or Co-insurance that would be required under the Plan for the covered services. For these claims, Medicare and the Plan pay you, and you are responsible for paying the provider's charge. The provider may charge you more than the Medicare or Blue Cross Blue Shield approved amounts.

If Medicare does not pay for a covered service, either because you have used up the benefits Medicare will pay, or it is not a Medicare benefit, the Plan will pay for covered services as if you were not covered by Medicare, based on the Blue Cross Blue Shield approved amount.

Private Duty Nursing Services

The Plan pays Blue Cross Blue Shield's approved amount for skilled care given by a private duty nurse in your home or in a hospital if:

- The patient's medical condition requires 24-hour care
- The patient requires medically necessary skilled care for a portion of the 24-hour period
- The skilled care (for example, ventilator care) is given by a professional registered nurse or licensed practical nurse
- The skilled care is given in a hospital because the hospital lacks intensive or cardiac care units or has no space in such units
- The skilled care is provided by a nurse who is not related to, or living with, the patient

The Plan does not pay for custodial care.

NOTE: Private duty nurses may require you to pay for services at the time they are provided. Submit an itemized statement to Blue Cross Blue Shield for the services. **All progress notes must be submitted with the**

claim. The Plan will pay the approved amount to you. Amounts paid in excess of amounts covered under the Plan do not count toward the annual out-of-pocket maximum.

Professional Ambulance Services

The Plan pays for ambulance services to transport a patient up to 25 miles. The Plan will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient's condition. In either case, the following conditions must be met:

- The service must be medically necessary because transport by any other means would endanger the patient's health.

- The service must be to transport the patient to a hospital or to transfer the patient between a hospital and another treatment location.

  NOTE: When ambulance service is used only to **transfer** the patient, the attending physician must prescribe the transfer.

- The service must be provided in a qualified vehicle

- The fee must be only for the transportation of the patient

Outpatient Diabetes Management Program

BCBSM Card Diabetes Benefits

Diabetes management medication, equipment and supplies should be obtained by using the BCBSM Card, which will be accepted as full payment by participating pharmacies. These will not be charged to your Miscellaneous, Prescription or Individual HRA Accounts – they are covered 100% as a Basic Benefit. Do not use your Benefit Advisor Card to obtain coverage for diabetic medications or supplies. The BCBSM Card works at most major pharmacies.

When you use your BCBSM Card, the Plan pays 100% of BCBSM's approved amount for the following covered items, regardless of whether you have Enhanced Coverage or Standard Coverage:

- Blood glucose monitors

- Blood glucose monitors for the legally blind

- Test strips for glucose monitors

- Visual reading and urine test strips

- Lancets

- Spring-powered lancet devices

- Syringes

- Insulin

- Nonexperimental drugs to control blood sugar

  NOTE: Coverage for syringes, insulin and diabetic prescription drug benefits is provided even though the plan normally does not cover prescription drugs.

- Insulin pumps
- Medical supplies required for the use of an insulin pump
- Diabetes self-management training conducted in a group setting, whenever practicable, if:
    - Self-management training is considered medically necessary upon diagnosis by an MD or DO who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
    - Your MD or DO diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
- The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health. Contact the Fund Office if you need reimbursement forms to submit for this coverage.

Reimbursement of Certain Diabetic Medications through the Fund Office

If you have diabetes, there is one type of prescription medication for which you may obtain 100% reimbursement through the Fund Office as a Basic Benefit, rather than through your Prescription Medicine Benefits, Miscellaneous Benefits, or Individual HRA: if you have diabetes and require medication that is prescribed by a doctor of podiatric medicine, MD or DO that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes, you must provide proof that the medication was prescribed to treat a condition related to diabetes and submit it to the Fund Office.

Contact the Fund Office if you have any problems obtaining 100% coverage for any diabetes management related items.

Voluntary Sterilization

The Plan provides coverage for hospital and physician services relating to voluntary sterilization, whether medically necessary or not, following a 90 day waiting period. This waiting period does not apply to patients who are under 19 years of age.

Autism Disorders

Covered Autism Spectrum Disorders

We pay for the diagnosis and outpatient treatment of Autism Spectrum Disorders, including: Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified, as described below.

Covered Services

Diagnostic services must be provided by a licensed physician or a licensed psychologist and include: assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule.

> Note: Before applied behavior analysis services will be covered, a BCBSM-approved autism evaluation center must evaluate and diagnose the member as having one of the covered autism spectrum disorders.

Treatment includes the following evidence-based care if prescribed or ordered by a licensed physician or licensed psychologist for a member who has been diagnosed with one of the covered autism spectrum disorders:

- **Applied behavior analysis treatment.** It must be provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

  Note: Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

  - **Applied behavior analysis treatment** is covered subject to the following requirements:

    - **Treatment Plan** – Applied behavior analysis treatment must be included in a treatment plan recommended by a BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition. If requested by BCBSM, the cost of treatment review will be paid by BCBSM.

    - **Prior Authorization** – Applied behavior analysis treatment must be approved for payment through BCBSM's prior authorization process. If prior authorization is not obtained, rendered services will not be covered and the member will be responsible to pay for those services. Prior authorization is not required for any other covered autism services.

- **Behavioral health treatment.** It includes evidence-based counseling that must be provided or supervised by a licensed psychologist, so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

- **Psychiatric care.** It includes evidence-based direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.

- **Psychological care.** It includes evidence-based direct or consultative services provided by a psychologist licensed in the state where he/she practices.

  Note: Benefits for autism disorders are in addition to any psychiatric, psychological and non-applied behavior analysis benefits that may be available under the Plan.

- **Therapeutic care.** It includes evidence-based physical therapy, occupational therapy, speech and language pathology, or other care performed by a licensed certified speech therapist, occupational therapist, physical therapist or social worker. Therapeutic care also includes nutritional therapy performed by a physician and genetic testing as recommended in the treatment plan.

<u>Coverage Requirements</u>

All autism services and treatment must be:

- Medically necessary and appropriate

- Comprehensive and focused on managing and improving the symptoms directly related to a member's Autism Spectrum Disorder.

- Deemed safe and effective by BCBSM.

  Note: Services or treatments that are deemed experimental or investigational by BCBSM, such as applied behavior analysis treatment, are covered only when they are approved by BCBSM and included in a treatment plan recommended by the BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition.

Limitations and Exclusions

In addition to those listed in the Plan, the following limitations and exclusions apply:

- Benefits for applied behavior analysis treatment are limited to children through the age of 18. This age limitation does not apply to psychiatric, psychological, non-applied behavior analysis services and services to diagnose autism.

- All autism benefits including, but not limited to, medical-surgical services and/or behavioral health treatment covered under the Plan are subject to any hospital/medical deductibles and coinsurance requirements.

- Any treatment that is not a covered benefit by BCBSM, including, but not limited to, sensory integration therapy and chelation therapy will not be paid.

- Conditions such as Rett's Disorder and Childhood Disintegrative Disorder are not payable under the Plan.

- When a member is treated with approved services for covered autism disorders, coverage for the services under this autism benefit overrides certain exclusions in the Plan such as exclusion of:

    - Experimental treatment

    - Treatment of chronic, developmental or congenital conditions

    - Treatment of learning disabilities or inherited speech abnormalities

    - Treatment solely to improve cognition, concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought.

- All autism services performed in Michigan must be provided by providers who are registered with BCBSM as a participating or nonparticipating provider.

- All autism services performed outside of Michigan must be provided by providers that participate with its local Blue Cross/Blue Shield plan.

SECTION 9

MEDICAL COVERAGE GENERAL CONDITIONS, LIMITATIONS AND EXCLUSIONS

This section lists and explains certain general conditions, limitations and exclusions that apply to your Plan. These conditions may make a difference in how, where and when benefits are available to you.

Assignment

The services provided under your Plan are for your personal benefit and cannot be transferred or assigned. Any attempt to assign benefits under your Plan will automatically terminate all your rights under it. No right to payment from the Plan, claim or cause of action against the Plan may be assigned by you to any provider. The Plan will not pay any provider except under the terms of the Plan.

Care and Services That Are Not Payable – In General

The Plan does not pay for the following care and services:

- Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under the Plan
- Those available in a hospital maintained by the state or federal government, unless payment is required by law
- Those payable by government-sponsored health care programs, such as Medicare, for which a Member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- In addition, the Plan provides certain benefits for Members enrolled in Medicare as provided under **Coverage for Other Health Care Services** in **"Medicare Supplemental Benefits."**
- Any services not listed in this Summary Plan Description and the Benefit Schedule as being payable.

Changes in Your Family and Special Enrollment Rights for Members who are Actively at Work

If you are Actively at Work, you may add your Spouse and Children to your coverage after the date you initially become eligible based on the rules in the following provisions. If you are not Actively at Work but are covered as a retiree (Normal, Early or Disability), your Spouse and Children can be added to coverage only when you first become eligible for coverage. If they are not enrolled at that time, they cannot be added later.

The following provisions apply only when you are Actively at Work (a Member who is not disabled, who is not retired, and who is working under the jurisdiction of UA Local 190).

If you have a new Spouse or Child as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your Spouse and your Children. This requires you to complete an enrollment/change of status form. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If you meet the 30-day deadline, coverage will take effect as of the date of the marriage, birth, adoption or placement for adoption. You also should notify the Administrative Manager of any divorce, death, address changes or the start of military service.

In addition, if you are declining enrollment for yourself, your Spouse or your Children because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Spouse and Children in this plan if you, your Spouse or your Children lost eligibility for that other coverage (or if an employer stops contributing towards your, your Spouse's or your Children's other coverage). However, you must request enrollment within 30 days after your, your Spouse's or your Children's other coverage ends (or after an employer

stops contributing toward the other coverage). If you meet the 30-day deadline, coverage will take effect as of the date of the loss or change in cost of the coverage. To request special enrollment or obtain more information, contact the Administrative Manager.

If you and/or your Spouse and/or your Children are eligible but not enrolled for coverage under this Plan, you may be able to enroll yourself and/or your Spouse and/or your Children this Plan under the following circumstances:

- You and/or your Spouse and/or your Children lose Medicaid or state Child Health Insurance Program coverage because you and/or your Spouse and/or your Children become ineligible for Medicaid or state Child Health Insurance Program coverage, or

- You and/or your Spouse and/or your Children become eligible for a premium assistance subsidy under Medicaid or a state Child Health Insurance Program.

You must request enrollment within 60 days of either of the above events in order to enroll under this Plan. If you meet this deadline, coverage will take effect as of the date of loss of Medicaid or state Child Health Insurance Program coverage.

The Plan must be notified within 30 days of any changes in your family if you want the change to relate back to the date of your change in circumstances.. This requires you to complete an enrollment/change of status form within the required time period. Your coverage changes will then take effect as of the date of the event. Changes include marriage, divorce, death, birth, adoption, address changes or the start of military service. **Except as otherwise provided above, if you fail to enroll a Spouse or Child or fail to notify the Administrative Manager of an eligible Spouse or Child within 30 days of a Spouse or Child becoming eligible, the Spouse or Child will not have coverage before the first day of the month following the date you file a satisfactorily completed enrollment/change of status form or Member Application for coverage for the Spouse or Child.**

Changes to Your Plan

Blue Cross Blue Shield employees, agents or representatives cannot agree to change or add to the benefits described in this Summary Plan Description.

- **Any changes must** be **in writing and approved by the Plan Trustees. The Trustees reserve the right to change or terminate benefits under the Plan at any time.**

- The Plan documents may add, limit, delete or clarify benefits.

Coordination of Benefits

The Plan coordinates the benefits payable under the Plan pursuant to the Michigan Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under the Plan are also covered and payable under another group health care plan, the Plan combines its payment with that of the other plan to pay the maximum amount it routinely pays for the covered services. See **Section 22, Coordination of Benefits and Subrogation**.

Coverage for Drugs and Devices

The Plan does not pay for any drug or device prescribed for uses or in dosages other than those specifically approved by the Food and Drug Administration. (This is often referred to as the off-label use of a drug or device.) However, the Plan will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing MD or DO can substantiate that the drug is recognized for treatment of the condition for which it is prescribed by one of the following:

- The American Medical Association Drug Evaluations

- The American Hospital Formulary Service Drug Information

- The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”

- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

  NOTE: Chemotherapeutic drugs are not subject to this general condition.

Deductibles, Co-insurance and Co-payments Paid Under Other Plans

The Plan does not pay deductibles, co-insurance or co-payments that you were required to pay under any other Plan.

Experimental Treatment

Services That Are Not Payable

The Plan does not pay for experimental treatment (including experimental drugs or devices) or services related to experimental treatment, except as explained under “Services That Are Payable" below. In addition, the Plan does not pay for administrative costs related to experimental treatment or for research management.

NOTE: The Plan does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

- The Blue Cross Blue Shield medical director is responsible for determining whether the use of any service is experimental. **The criteria that are used are explained in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.**

Services That Are Payable

The Plan does pay for experimental treatment and services related to experimental treatment when **all** of the following are met:

- Blue Cross Blue Shield considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).

- The treatment is covered under your Plan when it is provided as conventional treatment.

- The services related to the experimental treatment are covered under your Plan when they are related to conventional treatment.

- The experimental treatment and related services are provided during a Blue Cross Blue Shield-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by Blue Cross Blue Shield).

  NOTE: The Plan does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

- This section of the Summary Plan Description does not provide coverage for services not otherwise covered under your Plan.

- Drugs or devices provided to you during a Blue Cross Blue Shield -approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the Member's condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

Illness or Injuries Resulting from War

Services are not payable for the treatment of illness or injuries resulting from declared or undeclared military acts of war.

Improper Use of Plan Benefits

If you or any Spouse or Child allow any ineligible person to receive benefits (or try to receive benefits) under your Plan, or allow any eligible person to receive more than they are entitled to receive from the Plan, the Plan may take any of the following actions against you or your Spouse or Children:

- Refuse to pay benefits
- Cancel coverage
- Begin legal action
- Refuse to cover health care services at a later date
- Withhold benefit payments owed for services received by you, your Spouse or Children to recover the cost of benefits that should not have been paid, requiring you to pay your own medical costs.

Motor Vehicle Accident Injury Exclusion

The Plan will not cover services to treat an injury or condition that is a direct or indirect result of a motor vehicle accident under any circumstances.

A motor vehicle is considered a wheeled vehicle designed for operation on public roads or highways that is powered by something other than muscular power. Motor vehicle may include, but is not limited to, a car, truck, van, bus, semi-truck, trailer and/or motorcycle. A motor vehicle accident is an incident, loss, or damaging event involving the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle regardless of whether the accident also involves another object, structure, person, motor vehicle or non-motorized vehicle.

Some motor vehicle insurance (for example, motorcycle insurance) does not provide coverage for medical costs unless you request and pay for extra coverage. You should make sure you have motor vehicle medical expense coverage, because the Plan will not pay any claims that are the result of a motor vehicle accident.

Notification

When Blue Cross Blue Shield needs to notify you, the Plan mails the notice to your most recent address the Plan has in its records. This fulfills the Plan's obligation to notify you.

Other Coverage

In certain cases, we may have paid for health care services under your Plan that another person, insurance company or organization should have paid. In these cases, we have the right to recover payments you receive from someone else (a third party) to compensate you for your injury or illness, up to the amount the Plan paid relating to the illness or injury. We can recover these amounts no matter how the money you receive is characterized, even if

what you receive is described as not relating to medical expenses, and even if you only receive a partial recovery of what you claimed to be owed. See **Section 22, Coordination of Benefits and Subrogation**.

Payment of Covered Services

The covered services described in this Summary Plan Description, such as multiple surgeries or a series of services such as laboratory tests, are combined and paid according to payment policies adopted by Blue Cross Blue Shield.

Personal Costs

The Plan will not pay for:

- Transportation and travel, even if prescribed by a physician, except as provided under the Plan
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Physician of Choice

You may continue to receive services from the physician of your choice. The rules about participating providers do not prohibit you from seeing whatever physician you want to see. They only affect the amount we will pay.

Refunds of Premium

If the Plan determines that it must refund a self-pay or COBRA premium, it will refund up to a maximum of two years of payments.

Release of Information

You agree to permit providers to release information to Blue Cross Blue Shield and the Plan. This can include medical records and claims information related to services you may receive or have received.

Blue Cross Blue Shield and the Plan agree to keep this information confidential. Consistent with Blue Cross Blue Shield's and the Plan's Notices of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

Verbal verification of a Member's eligibility for coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, medical necessity verification, the availability of benefits at the time the claim is processed as well as to the conditions, limitations, exclusions, maximums and Co-payments under your coverage as stated in the official plan documents.

Right to Interpret Plan

During claims processing and internal grievances, the Plan reserves the right to interpret and administer the terms of the Plan and any amendments to the Plan. The Plan Administrator has full discretion to interpret the Plan Document when determining your rights. The Plan Administrator's final adverse decisions regarding claims processing and grievances are subject to your right to appeal under applicable law. See Section 21, Filing Claims and Appeals, for the claims and appeal procedures.

Semiprivate Room Availability

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you will be responsible for any additional cost. The Plan will not pay the difference between the cost of hospital rooms covered by your Plan and more expensive rooms.

Services Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this Summary Plan Description, the Plan will not pay for any services, treatment, care or supplies provided before your coverage under the Plan becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at a facility, the Plan's payment will be based on the facility's contract with Blue Cross Blue Shield. The Plan's 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 Plan coverage or after it ends.

Time Limit for Legal Action

Legal action against Blue Cross Blue Shield or the Plan may not begin later than two years after it has received a complete claim for services. No action or lawsuit may be started until after you have completely exhausted the claims review procedure. See **Section 21, Filing Claims and Appeals.**

Unlicensed Provider

Benefits are not payable for health care services provided by persons who are not legally qualified or licensed to provide such services.

Waiting Periods

There is a waiting period of 90 days for tonsillectomies and adenoidectomies and for voluntary sterilizations. The waiting period does not apply to patients who are under 19 years of age. See the Summary Plan Description. There is no waiting period for the treatment of pre-existing conditions effective January 1, 2014.

What Laws Apply

The Plan will be interpreted under the laws of the state of Michigan and the federal law known as "ERISA" (the Employee Retirement Income Security Act of 1974, as amended).

Workers Compensation

The Plan does not pay for the treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer.

Miscellaneous Exclusions

Your Basic Benefits are subject to the exclusions and limitations listed below. Most of these are listed elsewhere in this SPD. If not, then these are in addition to limitations listed elsewhere in this SPD.

If you are denied coverage for any reason, please contact the Administrative Manager's Office.

The following benefits are not Basic Benefits:

Inpatient Hospital Services That Are Not Payable

- Services that may be medically necessary but can be provided safely in an outpatient or office location
- Services of physicians and surgeons not employed by the hospital (see **Coverage for Physician and Other Professional Provider Services**)
- Custodial care or rest therapy
- Psychological tests if used as part of, or in connection with, vocational guidance training or vocational counseling
- Human organ transplants, except those specifically listed in this Summary Plan Description.
- Dental services. However, certain procedures may be payable as medical services if performed in a hospital because the patient has a dental condition that is adversely affecting medical condition under circumstances specified in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.
- Services covered under any other health care benefits plan
- Artificial and endodontic implants and related services, including repair and maintenance of implants and surrounding tissue

Hospital Admissions That Are Not Payable

- Those for care that is not considered acute, such as:
    - Observation
    - Dental treatment, including extraction of teeth, except as otherwise noted in this Summary Plan Description
    - Diagnostic evaluations
    - Lab exams
    - Electrocardiography
    - Weight reduction (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
    - X-rays, exams or therapy
    - Cobalt or ultrasound studies
    - Basal metabolism tests
    - Convalescence or rest care
    - Convenience
- Those mainly for physical therapy, speech and language pathology services or occupational therapy

Outpatient Hospital Services That Are Not Payable

The services listed under "Inpatient Hospital Services That Are Not Payable" are also not payable when provided as outpatient care. In addition, we do not pay for:

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

Mental Health Services That Are Not Payable

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Marital counseling (but family counseling is available to the Spouse of a patient receiving counseling)

Substance Use Disorder Treatment Services Not Payable

- Services provided primarily for a diagnosis other than substance use disorder
- Dispensing methadone or testing urine specimens, unless you are receiving therapy, counseling or psychological testing
- Diversional therapy
- Services provided beyond the period necessary for care and treatment
- Services provided during the portion of any residential admission that occurs before the effective date of this Plan

Other Services That Are Not Payable

- Services by a nonparticipating ambulatory surgery facility
- Physical therapy, speech and language pathology services, and occupational therapy services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance use disorder treatment program
- Physical therapy, speech and language pathology services, and occupational therapy services provided to you in the home
- Services provided by a nonparticipating end stage renal disease facility
- Services not provided by the employees of the ESRD facility
- Freestanding ESRD facility services not related to the dialysis process
- Services in a nonparticipating long-term acute care hospital including emergency services
- Inpatient long-term acute care hospital admissions that Blue Cross Blue Shield has not preapproved
- Out-of-state long-term acute care hospital admissions, except with special approval from the Administrative Manager
- Home health care provider general housekeeping services
- Home health care provider transportation to and from a hospital or other facility
- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.) provided by a home health care provider
- Home health care provider custodial care or nonskilled care
- Services performed by a nonparticipating home health care provider

- Services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.

- Services provided by any of the following providers when they are nonparticipating providers:

    - outpatient physical therapy facilities,
    - freestanding ambulatory surgery facilities,
    - skilled nursing facilities,
    - hospice programs,
    - long-term acute care facilities,
    - home health care agencies,
    - home infusion therapy providers

- Services at a nonparticipating hospital or facility other than those needed to treat an accidental injury or medical emergency

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

- Screening services, except as provided in **Preventive Care** under **Coverage for Other Health Care Services.**

- Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed in **Surgery**, above.

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

- Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization)

- Weight loss programs (except for bariatric surgery available only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)

    Prescription medicines provided by a pharmacy; see Section 10 for your separate non-Blue Cross Blue Shield Prescription Medicine Benefits

- Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

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

- Services provided during nonemergency medical transport

- Experimental treatment

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

- Hearing aids or services to examine, prepare, fit or obtain hearing aids except as provided in **Hearing Care** under **Coverage for Other Health Care Services**.

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

- Hospital services, including services provided by hospital employees, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.

- Drugs, medical appliances, materials or supplies and blood transfusions, except as provided in **Coverage for Hospital, Facility and Alternatives to Hospital Care**.

- Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, **except** as provided in detail in the detailed Benefit Schedule, a free copy of which is available from the Administrative Manager on request.

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

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

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

- Infertility services that do not treat a medical condition, other than infertility. This can include services such as:

    - Sperm washing
    - Post-coital test
    - Monitoring of ovarian response to ovulatory stimulants
    - In vitro fertilization
    - Ovarian wedge resection or ovarian drilling
    - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
    - Diagnostic studies done for the sole purpose of infertility assessment
    - Any procedure done to enhance reproductive capacity or fertility

- The following services provided by a Certified Nurse Practitioner:

    - Services not covered by your Plan
    - Services performed when you are a hospital inpatient

- Reversal of sterilization procedures.

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

- Psychological tests for vocational guidance or vocational counseling.

- Care and services payable by government-sponsored health care programs, such as Medicare or CHAMPUS, for which a Participant is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs.

- Dialysis services after 30 months of ESRD treatment.

- Services that are not included in the certificate and riders that are part of the contract between the Plan and Blue Cross Blue Shield.

- Testing and treatment for sexual dysfunctions not related to organic disease.

NOTE: You or your physician can call Blue Cross Blue Shield to determine if other proposed services are not covered benefits under your Plan.

SECTION 10

MISCELLANEOUS BENEFITS AND PRESCRIPTION MEDICINE BENEFITS

What about items not covered by Basic Benefits administered by Blue Cross Blue Shield?

Basic Benefits are paid by the Fund to Blue Cross Blue Shield, which pays the providers of Basic Benefit services directly. Prescription medicines, vision expenses, dental expenses and other miscellaneous services are not part of Basic Benefits. Services and items not covered by Basic Benefits may be covered separately by the Fund through your Benefit Advisor Card or an arrangement that allows you to be reimbursed for expenses you pay yourself. You should use the Benefit Advisor Card to obtain Prescription Medicine Benefits (for which you should also use the Blue Cross Blue Shield of Michigan Card) and dental and vision Miscellaneous Benefits.

The Fund provides reimbursements up to certain limits for each active and retired Member: a Prescription Medicine Benefit for prescription medicine reimbursements, and a Miscellaneous Benefit for items and services that meet IRS requirements for medical coverage but are not covered by the Basic Benefits. For claims that are submitted manually (other than prescription claims) to be eligible for payment, all claims for reimbursements under these reimbursement funds must be submitted to the Fund Office by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued.

Prescription Medicine Benefit

What do I do if I need a prescription filled?

The Fund provides a Prescription Medicine Benefit separate from Blue Cross Blue Shield Basic Benefits. The maximum reimbursement for a year is $1,440. Unused amounts for one year do not carry forward to any later year. Amounts you pay in excess of $1,440 do not count toward the annual out-of-pocket maximum.

To get a prescription filled, go to your pharmacy and present your Blue Cross Blue Shield of Michigan Card and your Benefit Advisor Card. If the pharmacy does not accept VISA, or rejects the Benefit Advisor Card for any other reason**, you should still present and use the Blue Cross Blue Shield of Michigan Card**, and then submit the receipt to the Fund Office if you still have Prescription Medicine Benefits, Miscellaneous Benefits, or Individual HRA Benefits left for the year.

Prescriptions should be paid through use of both the Benefit Advisor Card and the Blue Cross Blue Shield of Michigan Card. Prescriptions purchased without the use of your Blue Cross Blue Shield of Michigan Card will not be counted towards the TrOOP annual out-of-pocket limit. The Blue Cross Blue Shield of Michigan Card approves your prescription for payment by this Plan. The Benefit Access Card then processes the payment from your available funds.

Remember that if you are a Medicare-Eligible Retiree, your prescription medicine costs will not count towards the TrOOP annual out-of-pocket limit.

How do I pay for diabetes medications and supplies?

You can use your Blue Cross Blue Shield of Michigan Card to pay for diabetes medications and supplies. **Your Benefit Advisor Card is not necessary.** By using the Blue Cross Blue Shield of Michigan Card, you obtain your diabetes-related medicines and supplies as a **Basic Benefit**. There is no limitation on the Prescription Medicine Benefit for diabetes-related medications and supplies.

What if I am eligible for Medicare Part D coverage?

For Medicare eligible Members, the Fund will reimburse eligible Medicare Part D coverage premiums (Medicare Part D coverage premiums that do not exceed the standard Medicare Part D premium amount for each month) from your available Prescription Medicine Account. Until further notice, the eligible Medicare Part D premium amount for each month is $36 per month. The total maximum Prescription reimbursement for the year, including Part D premiums, still will not exceed $1,440. If this limit is changed, the Administrative Manager will notify eligible Members.

The Administrative Manager will reserve the portion of Medicare Part D covered Members' annual limit needed to pay the eligible Medicare Part D premiums for the entire year to ensure that the maximum eligible Medicare Part D premiums will be covered. If a Member wishes to have the full limit applied to other eligible expenses, a written waiver can be signed and the remaining annual limit will be applied to other eligible expenses instead of being reserved for, and applied to, the remaining Medicare Part D premiums.

In addition, even though the Prescription Medicine Benefit normally does not reimburse deductibles, co-insurance or co-pays, for Medicare eligible Members, until further notice the Fund will reimburse a maximum of $310 of claims paid by the Member because of the Medicare Part D deductible. If this limit is changed, the Administrative Manager will notify eligible Members.

Effective January 1, 2014, the Medicare Part D co-pay is eligible for reimbursement by the Fund. This means that any prescription drug co-pay imposed by the Medicare prescription drug plan is eligible for reimbursement from the Prescription Medicine and Miscellaneous Benefits Accounts.

Example for a Member who is not eligible for Medicare: The Fund will reimburse $1,440 of Prescription Medicine Benefits expenses submitted for the year. **Example for a Medicare-eligible Member:** For a Medicare-eligible Member who gets reimbursed for the full $432 of eligible Medicare Part D premiums from Prescription Medicine Benefits ($36 per month for 12 months), the Fund would reimburse $1,008 of other eligible prescription expenses submitted for the year. The Administrative Manager will treat this Member as having only $1,008 of Prescription Medicine Benefits available for the year in order to reserve the full $432 of premiums ($36 per month) for the entire year. If the Member exceeded the $1,008 earlier in the year and wanted to apply the remainder of the Member's annual limit to eligible prescription costs, the reserve would become available once the Member signed a waiver form. **Note that the Benefit Advisor Card cannot be used to pay for Medicare Part D premiums**.

Miscellaneous Benefit

What do I do if I need a service not covered by the Blue Cross Blue Shield Basic Benefits or need additional prescriptions after using up the Prescription Benefit?

The Fund provides a separate **Miscellaneous Benefit** amount for each Participant. The maximum reimbursement for a year is $1,800 per family (Participant, Spouse and Children combined). Unused amounts for one year do not carry forward to any later year.

What expenses are eligible for reimbursement under Miscellaneous Benefits?

The Miscellaneous Benefit covers expenses (up to a total of $1,800) that meet the following criteria:

- The expense is the type of expense that would be eligible for the medical expense deduction on your U.S. Individual Income Tax Return (without taking into account the income percentage rules); and
- The expense is not an insurance premium, long-term care contract expense or premium, or long-term nursing home expense;
- If the expense is for vitamins, medicine or supplies other than insulin, it is covered only if prescribed by a physician for a specific disease or condition; and

- The expense would not be paid or covered by any health plan (other than the Fund), Workers' Compensation Insurance, automobile insurance, government or other source if the Miscellaneous Benefit did not exist.

- If the expense is for services, the expense is for services that have been rendered during the year or will be rendered during the current year. For example, the current year Miscellaneous Benefit cannot be used to pay for orthodontia services that will be rendered in later years.

- The Deductible, Co-pay and Co-insurance amounts that are not covered by Basic Benefits are not covered by Miscellaneous Benefits.

- The only exception to the "no insurance premium" rule is that any Medicare Part D insurance premiums that would be eligible for reimbursement under the Prescription Medicine Benefit are eligible for reimbursement under Miscellaneous Benefits after the Prescription Medicine Benefit maximum for the year has been used up.

- The 50% Delta Dental co-payment is covered by Miscellaneous Benefits

The medical expense deduction for income taxes allows deduction of a wide variety of medical expenses if they exceed a certain percentage of your income for the year. We ignore the IRS percentage of income rule - the percentage of income rule does not apply for purposes of the Miscellaneous Benefit. The Miscellaneous Benefit uses the IRS definition because it is the broadest possible benefit that can be paid to you tax-free. The expenses must be paid for the diagnosis, cure, mitigation (lessening), treatment, or prevention of a specific disease or for treatments affecting a specific part or function of the body. The expenses must be primarily to relieve or prevent a specific physical or mental defect or illness. Expenses that qualify and do not qualify for this deduction are listed and explained in IRS Publication 502. See the **selective excerpt from Publication 502** provided at the end of this section, which has been modified to fit this Plan.

The Plan Administrator will look to Publication 502 and other IRS guidance to determine what is and is not an eligible expense. However, determinations of this sort often require exercise of judgment and weighing of the facts of each particular situation. The Plan Administrator has broad discretion to make the determination of what is eligible within these guidelines, and the Plan Administrator's decision will be final and binding in all respects, subject to the usual claims appeal rights described in **Section 21, Filing Claims and Appeals**.

Some examples of expenses that are covered by the Miscellaneous Benefit if not covered elsewhere are: eye exams, corrective lenses, contacts, hearing care services and devices, dental expenses, oral surgery expenses, doctors' fees for office visits that do not meet the Blue Cross Blue Shield criteria, medically necessary items such as medical equipment rental and medical appliances that do not meet Blue Cross Blue Shield criteria, surgical and hospital expenses in excess of Basic Benefits, and your share of the cost of Basic Benefits provided by someone who is not a Blue Cross Blue Shield participating provider.

Will the Fund pay for expenses caused by an injury or illness sustained during employment?

No coverage is provided for illness or injury sustained during the course of any employment for wage or profit because these costs are covered by Workers' Compensation Insurance. This protects the Fund from expenses that are covered by or should have been claimed through the Workers' Compensation system.

How do I collect my Miscellaneous Benefits?

Miscellaneous Benefits will be paid through your Benefit Advisor Card. For expenses incurred with service providers that do not accept the Benefit Advisor Card for a qualifying expense, submit proof of the expense, such as a vision expense receipt or Explanation of Benefits from Blue Cross Blue Shield or Delta Dental or other written proof of the expense and its medical necessity to the Administrative Manager. Contact the Administrative Manager at the address or phone number listed at the end of this SPD if you have questions on what is needed to obtain reimbursement. The Fund Office will issue a check for the covered amount payable to you or, upon request, your medical provider if, after reviewing the claim, it is determined that the expense is an eligible expense and you have benefits available under the annual limit.

How do the Prescription Medicine Benefits, Miscellaneous Benefits and Individual HRA Benefits coordinate with each other under the Benefit Advisor Card?

Depending on the nature of the expense, the Benefit Advisor Card will deduct the expense from your account balances as follows:

- If the expense is a prescription and you use your Blue Cross Blue Shield of Michigan Card, it will first be deducted from your Prescription Medicine Benefits account, then from your Miscellaneous Benefits account and then from your Individual HRA account.

- If the expense is a dental or vision expense, or a prescription after your Prescription Medicine Benefits account has been used up, it will first be deducted from your Miscellaneous Benefits account, and then from your Individual HRA account.

- If the expense is incurred at a hospital or doctor's office, or other health care provider facility, or is a prescription, dental or vision expense and your Prescription Medicine Benefits account and Miscellaneous Benefits account are used up, it will be deducted from your Individual HRA account.

- When you use your Benefit Advisor Card for medical expenses other than vision, dental or prescription medicines, funds will be automatically taken from your Individual HRA account first, even if you still have amounts available under your Miscellaneous Benefits account. The card works this way because most items other than dental, vision or prescription expenses will be Deductibles, Co-payments or Co-insurance, all of which are only reimbursable from the Individual HRA. If you have a medical expense at a hospital or doctor's office that is not covered by Blue Cross Blue Shield, such as a non-participating provider expense, you can use Miscellaneous Benefit funds only by submitting the claim to the Fund Office. In effect, this means your Individual HRA account is now "primary" for miscellaneous medical expenses that are paid using the Benefit Advisor Card other than prescriptions, vision, or dental expenses. Your Miscellaneous Benefits account is "secondary" for medical expenses other than vision, dental or prescription medicine expenses when the Benefit Advisor Card is used, and if you have no Individual HRA balance left and have Miscellaneous Benefits left, you will need to manually submit those expenses to the Fund Office.

Selective Excerpts from IRS Publication 502

Following are examples of the types of expenses that can be reimbursed under the Miscellaneous Benefit. If you can include an expense in medical expenses under the following criteria, it is eligible for reimbursement under the Miscellaneous Benefit, subject to the limits and restrictions already explained above. Note that any reference to "dependent" or "dependents" in this section mean only a Spouse or Child as defined for purposes of this Plan.

Medical and Dental Expenses

What Medical Expenses Are Deductible?

Following is a list of items that you **can** include in figuring your medical expense deduction. The items are listed in alphabetical order.

Abortion

You can include in medical expenses the amount you pay for a legal abortion.

Acupuncture

You can include in medical expenses the amount you pay for acupuncture.

Alcoholism

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment. You can also include in medical expenses transportation costs you pay to attend meetings of an Alcoholics Anonymous Club in your community if your attendance is pursuant to medical advice that membership in the Alcoholics Anonymous Club is necessary for the treatment of a disease involving the excessive use of alcoholic liquors.

Ambulance

You can include in medical expenses amounts you pay for ambulance service.

Artificial Limb

You can include in medical expenses the amount you pay for an artificial limb.

Artificial Teeth

You can include in medical expenses the amount you pay for artificial teeth.

Autoette

See **Wheelchair**, later.

Birth Control Pills

You can include in medical expenses the amount you pay for birth control pills prescribed by a doctor.

Braille Books and Magazines

You can include in medical expenses the part of the cost of Braille books and magazines for use by a visually-impaired person that is more than the cost of regular printed editions.

Capital Expenses

You can include in medical expenses amounts you pay for special equipment installed in your home, or for improvements, if their main purpose is medical care for you, your spouse, or your child. The cost of permanent improvements that increase the value of the property may be partly included as a medical expense. The cost of the improvement is reduced by the increase in the value of the property. The difference is a medical expense. If the value of the property is not increased by the improvement, the entire cost is included as a medical expense.

Certain improvements made to accommodate your home to your disabled condition, or that of your Spouse or your Children who live with you, do not usually increase the value of the home and the cost can be included in full as medical expenses. These improvements include, but are not limited to, the following items.

- Constructing entrance or exit ramps for your home.
- Widening doorways at entrances or exits to your home.
- Widening or otherwise modifying hallways and interior doorways.
- Installing railings, support bars, or other modifications to bathrooms.
- Lowering or modifying kitchen cabinets and equipment.

- Moving or modifying electrical outlets and fixtures.
- Installing porch lifts and other forms of lifts but generally not elevators.
- Modifying fire alarms, smoke detectors, and other warning systems.
- Modifying stairways.
- Adding handrails or grab bars anywhere (whether or not in bathrooms).
- Modifying hardware on doors.
- Modifying areas in front of entrance and exit doorways.
- Grading the ground to provide access to the residence.

Only reasonable costs to accommodate a home to a disabled condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not medical expenses.

Example. You have a heart ailment. On your doctor's advice, you install an elevator in your home so that you will not have to climb stairs. The elevator costs $8,000. An appraisal shows that the elevator increases the value of your home by $4,400. You figure your medical expense like this:

$8,000 (cost) minus $4,400 (increase in value) = $3,600 (medical expense).

Operation and upkeep. Amounts you pay for operation and upkeep of a capital asset qualify as medical expenses, as long as the main reason for them is medical care. This is so even if none or only part of the original cost of the capital asset qualified as a medical care expense.

Example. If, in the previous example, the elevator increased the value of your home by $8,000, you would have no medical expense for the cost of the elevator. However, the cost of electricity to operate the elevator and any costs to maintain it are medical expenses as long as the medical reason for the elevator exists.

Improvements to property rented by a person with a disability. Amounts paid by a person with a disability to buy and install special plumbing fixtures, mainly for medical reasons, in a rented house are medical expenses.

Example. John has arthritis and a heart condition. He cannot climb stairs or get into a bathtub. On his doctor's advice, he installs a bathroom with a shower stall on the first floor of his two-story rented house. The landlord did not pay any of the cost of buying and installing the special plumbing and did not lower the rent. John can include in medical expenses the entire amount he paid.

Car

You can include in medical expenses the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.

- **Special design**. You can include in medical expenses the difference in the cost of a car specially designed to hold a wheelchair and a regular car.
- **Cost of operation**. You cannot deduct the cost of operating a specially equipped car, except as discussed under **Transportation**, later.

Chiropractor

You can include in medical expenses fees you pay to a chiropractor for medical care.

Christian Science Practitioner

You can include in medical expenses fees you pay to Christian Science practitioners for medical care.

Contact Lenses

You can include in medical expenses amounts you pay for contact lenses needed for medical reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner. See also **Eyeglasses** and **Laser Eye Surgery**, later.

Crutches

You can include in medical expenses the amount you pay to buy or rent crutches.

Dental Treatment

You can include in medical expenses the amounts you pay for dental treatment. This includes fees paid to dentists for X-rays, fillings, braces, extractions, dentures, etc.

Drug Addiction

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging at the center during treatment.

Drugs

See **Medicines**, later.

Eyeglasses

You can include in medical expenses amounts you pay for eyeglasses and contact lenses needed for medical reasons. You can also include fees paid for eye examinations.

Fertility Enhancement

You can include in medical expenses the cost of the following procedures to overcome your inability to have children.

- Procedures such as in vitro fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse prior surgery that prevents you from having children.

Guide Dog or other Animal

You can include in medical expenses the cost of a guide dog or other animal to be used by a visually impaired or hearing-impaired person. You can also include the cost of a dog or other animal trained to assist persons with other physical disabilities. Amounts you pay for the care of these specially trained animals are also medical expenses.

Health Institute

You can include in medical expenses fees you pay for treatment at a health institute only if a physician prescribes the treatment and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.

Hearing Aids

You can include in medical expenses the cost of a hearing aid and the batteries you buy to operate it.

Home Care

See **Nursing Services**, later.

Hospital Services

You can include in medical expenses amounts you pay for the cost of inpatient care at a hospital or similar institution if the main reason for being there is to receive medical care. This includes amounts paid for meals and lodging. Also see **Lodging**, later.

Laboratory Fees

You can include in medical expenses the amounts you pay for laboratory fees that are part of your medical care.

Laser Eye Surgery

You can include in medical expenses the amount you pay for surgery to improve vision, such as radial keratotomy or other laser eye surgery, if it is done primarily to promote the correct function of the eye.

Lead-Based Paint Removal

You can include in medical expenses the cost of removing lead-based paints from surfaces in your home to prevent a child who has or has had lead poisoning from eating the paint. These surfaces must be in poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area is not a medical expense.

If, instead of removing the paint, you cover the area with wallboard or paneling, treat these items as capital expenses. See **Capital Expenses**, earlier. Do not include the cost of painting the wallboard as a medical expense.

Learning Disability

You can include in medical expenses tuition fees you pay to a special school for a Child who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders. Your doctor must recommend that the Child attend the school. See **Schools and Education, Special**, later. You can also include tutoring fees you pay on your doctor's recommendation for the Child's tutoring by a teacher who is specially trained and qualified to work with children who have severe learning disabilities.

Legal Fees

You can include in medical expenses legal fees you paid that are necessary to authorize treatment for mental illness. However, you cannot include in medical expenses fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not necessary for medical care.

Lodging

You can include in medical expenses the cost of meals and lodging at a hospital or similar institution if your main reason for being there is to receive medical care. See **Nursing Home**, later.

You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. You can include the cost of such lodging while away from home if you meet all of the following requirements:

- The lodging is primarily for and essential to medical care.

- The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.

- The lodging is not lavish or extravagant under the circumstances.

- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount you include in medical expenses for lodging cannot be more than $50 for each night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included.

Do not include the cost of your lodging while you are away from home for medical treatment if you do not receive that treatment from a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital or if that lodging is not primarily for or essential to the medical care you are receiving.

Meals

You can include in medical expenses the cost of meals at a hospital or similar institution if the main purpose for being there is to get medical care. You cannot include in medical expenses the cost of meals that are not part of inpatient care.

Medical Conferences

You can include in medical expenses amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of you, your Spouse, or your Child. The costs of the medical conference must be primarily for and necessary to the medical care of you, your Spouse, or your Child. You must spend the majority of your time at the conference attending sessions on medical information.

The cost of meals and lodging while attending the conference is not deductible as a medical expense.

Medical Information Plan

You can include in medical expenses amounts paid to a plan that keeps your medical information so that it can be retrieved from a computer data bank for your medical care.

Medical Expenses

- You can include in medical expenses amounts that are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

- Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medicines

You can include in medical expenses amounts you pay for prescribed medicines and drugs. You can also include amounts you pay for insulin. Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed. (**Note that the 20% co-pay under the Prescription Medicine Benefit is not eligible for reimbursement as a Miscellaneous Benefit.)**

Controlled substances. You cannot include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.), in violation of federal law.

Mentally Retarded, Special Home for

You can include in medical expenses the cost of keeping a mentally retarded person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living.

Nursing Home

You can include in medical expenses the cost of medical care in a nursing home or home for the aged for yourself, your Spouse, or your Children. This includes the cost of meals and lodging in the home if the main reason for being there is to get medical care. Do not include the cost of meals and lodging if the reason for being in the home is personal. You can, however, include in medical expenses the part of the cost that is for medical or nursing care.

Nursing Services

You can include in medical expenses wages and other amounts you pay for nursing services. A nurse need not perform services as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided in your home or another care facility.

Generally, only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, these amounts must be divided between the time spent performing household and personal services and the time spent for nursing services. However, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. See **Long-Term Care Contracts, Qualified**, earlier. Additionally certain expenses for household services or for the care of a qualifying individual incurred to allow you to work may qualify for the child and dependent care credit. See **Publication 503, Child and Dependent Care Expenses**. You can also include in medical expenses part of the amount you pay for that attendant's meals. Divide the food expense among the household members to find the cost of the attendant's food. Then apportion that cost in the same manner, as in the preceding paragraph. If you had to pay additional amounts for household upkeep because of the attendant, you can include the extra amounts with your medical expenses. This includes extra rent or utilities you pay because you moved to a larger apartment to provide space for the attendant.

Employment taxes. You can include as a medical expense social security tax, FUTA, Medicare tax, and state employment taxes you pay for a nurse, attendant, or other person who provides medical care. For information on employment tax responsibilities of household employers, see **Publication 926, Household Employer's Tax Guide**.

Healthy baby. You cannot include the cost of nursing services for a normal, healthy baby.

Operations

You can include in medical expenses amounts you pay for legal operations that are not for unnecessary cosmetic surgery. See **Cosmetic Surgery** under **What Expenses Are Not Deductible**, later.

Optometrist

See **Eyeglasses**, earlier.

Organ Donors

See **Transplants**, later.

Osteopath

You can include in medical expenses amounts you pay to an osteopath for medical care.

Oxygen

You can include in medical expenses amounts you pay for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.

Prosthesis

See **Artificial Limb**, earlier.

Psychiatric Care

You can include in medical expenses amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill Spouse or Child at a specially equipped medical center where the Spouse or Child receives medical care. See **Psychoanalysis**, next, and **Transportation**, later.

Psychoanalysis

You can include in medical expenses payments for psychoanalysis. However, you cannot include payments for psychoanalysis that you must get as a part of your training to be a psychoanalyst.

Psychologist

You can include in medical expenses amounts you pay to a psychologist for medical care.

Schools and Education, Special

You can include in medical expenses payments to a special school for a mentally impaired or physically disabled person if the main reason for using the school is its resources for relieving the disability. You can include, for example, the cost of:

- Teaching Braille to a visually impaired Child.
- Teaching lip reading to a hearing impaired Child.
- Giving remedial language training to correct a condition caused by a birth defect.

The cost of meals, lodging, and ordinary education supplied by a special school can be included in medical expenses only if the main reason for the child's being there is the resources the school has for relieving the mental or physical disability.

You cannot include in medical expenses the cost of sending a problem Child to a special school for benefits the Child may get from the course of study and the disciplinary methods.

Sterilization

You can include in medical expenses the cost of a legal sterilization (a legally performed operation to make a person unable to have children).

Stop-Smoking Programs

You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Surgery

See **Operations**, earlier.

Telephone

You can include in medical expenses the cost and repair of special telephone equipment that lets a hearing-impaired person communicate over a regular telephone.

Television

You can include in medical expenses the cost of equipment that displays the audio part of television programs as subtitles for hearing-impaired persons. This may be the cost of an adapter that attaches to a regular set. It also may be the portion of the cost of a specially equipped television that exceeds the cost of the same model regular television set.

Therapy

You can include in medical expenses amounts you pay for therapy you receive as medical treatment.

"Patterning" exercises. You can include in medical expenses amounts you pay to an individual for giving "patterning" exercises to a mentally retarded Child. These exercises consist mainly of coordinated physical manipulation of the Child's arms and legs to imitate crawling and other normal movements.

Transplants

You can include in medical expenses payments you make for surgical, hospital, laboratory, and transportation expenses for a donor or a possible donor of a kidney or other organ. You cannot include expenses if you did not pay for them.

A donor or possible donor can include surgical, hospital, laboratory, and transportation expenses in medical expenses only if he or she pays for them.

Transportation

You can include in medical expenses amounts paid for transportation primarily for, and essential to, medical care.

You can include:

- Bus, taxi, train, or plane fares, or ambulance service.
- Transportation expenses of a parent who must go with a Child who needs medical care.
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone.
- Transportation expenses for regular visits to see a mentally ill Spouse or Child, if these visits are recommended as a part of treatment.

You cannot include:

- Transportation expenses to and from work, even if your condition requires an unusual means of transportation.

- Transportation expenses if, for nonmedical reasons only, you choose to travel to another city, such as a resort area, for an operation or other medical care prescribed by your doctor.

Car expenses. You can include out-of-pocket expenses for your car, such as gas and oil, when you use your car for medical reasons. You cannot include depreciation, insurance, general repair, or maintenance expenses.

If you do not want to use your actual expenses, you can use a standard rate of **10 cents a mile** for use of your car for medical reasons.

You can also include the cost of parking fees and tolls. You can add these fees and tolls to your medical expenses whether you use actual expenses or use the standard mileage rate.

Example. Bill Jones drove 2,800 miles for medical reasons during the year. He spent $200 for gas, $5 for oil, and $50 for tolls and parking. He wants to figure the amount he can include in medical expenses both ways to see which gives him the greater deduction. He figures the actual expenses first. He adds the $200 for gas, the $5 for oil, and the $50 for tolls and parking for a total of $255.

He then figures the standard mileage amount. He multiplies the 2,800 miles by 10 cents a mile for a total of $280. He then adds the $50 tolls and parking for a total of $330.

Bill includes the $330 of car expenses with his other medical expenses for the year because the $330 is more than the $255 he figured using actual expenses.

Trips

You can include in medical expenses amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You may be able to include up to $50 per night for lodging. See **Lodging**, earlier.

You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or general improvement of health, even if you make the trip on the advice of a doctor.

Tuition

You can include in medical expenses charges for medical care included in the tuition of a college or private school, if the charges are separately stated in the bill or given to you by the school. See **Learning Disability**, earlier, and **Schools and Education, Special**, earlier.

Vasectomy

You can include in medical expenses the amount you pay for a vasectomy.

Weight-Loss Program

You can include in medical expenses the cost of a weight-loss program undertaken at a physician's direction to treat an existing disease (such as heart disease). But you cannot include the cost of a weight-loss program if the purpose of the weight control is to maintain your general good health.

Wheelchair

You can include in medical expenses amounts you pay for an autoette or a wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and keeping up the autoette or wheelchair is also a medical expense.

X-ray Fees

You can include in medical expenses amounts you pay for X-rays that you get for medical reasons.

What Expenses Are Not Deductible?

Following is a list of some items that you **cannot** include in figuring your medical expense deduction. The items are listed in alphabetical order.

Baby Sitting, Child Care, and Nursing Services for a Normal, Healthy Baby

You cannot include in medical expenses amounts you pay for the care of your Children even if the expenses enable you to get medical or dental treatment. Also, any expense allowed as a childcare credit cannot be treated as an expense paid for medical care. See also **Healthy baby** under **Nursing Services**, earlier.

Controlled Substances

You cannot include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.). Such substances may be legalized by state law. However, they are in violation of federal law and cannot be included in medical expenses.

Cosmetic Surgery

Generally, you cannot include in medical expenses the amount you pay for unnecessary cosmetic surgery. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. Procedures such as face-lifts, hair transplants, hair removal (electrolysis), and liposuction generally are not deductible.

You can include in medical expenses the amount you pay for cosmetic surgery if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Dancing Lessons

You cannot include the cost of dancing lessons, swimming lessons, etc., even if a doctor recommends them, if they are only for the improvement of general health.

Diaper Service

You cannot include in medical expenses the amount you pay for diapers or diaper services, unless they are needed to relieve the effects of a particular disease.

Electrolysis or Hair Removal

See **Cosmetic Surgery**, earlier.

Funeral Expenses

You cannot include in medical expenses amounts you pay for funerals.

Hair Transplant

See **Cosmetic Surgery**, earlier.

Health Club Dues

You cannot include in medical expenses health club dues, YMCA dues, or amounts paid for steam baths for your general health or to relieve physical or mental discomfort not related to a particular medical condition. You cannot include in medical expenses the cost of membership in any club organized for business, pleasure, recreation, or other social purpose.

Household Help

You cannot include in medical expenses the cost of household help, even if a doctor recommends such help. This is a personal expense that is not deductible. However, you may be able to include certain expenses paid to a person providing nursing-type services. Also, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses.

Illegal Operations and Treatments

You cannot include in medical expenses amounts you pay for illegal operations, treatments, or controlled substances whether rendered or prescribed by licensed or unlicensed practitioners.

Insurance Premiums for Certain Types of Policies

This Plan does not cover insurance premiums paid by you for any type of insurance policy.

Maternity Clothes

You cannot include in medical expenses amounts you pay for maternity clothes.

Nonprescription Drugs and Medicines

Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Personal Use Items

You cannot include in medical expenses an item ordinarily used for personal, living, or family purposes unless it is used primarily to prevent or alleviate a physical or mental defect or illness. For example, the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease can be included with medical expenses. Where an item purchased in a special form primarily to alleviate a physical defect is one that in normal form is ordinarily used for personal, living, or family purposes, the excess of the cost of the special form over the cost of the normal form is a medical expense (see **Braille Books and Magazines** under ***What Medical Expenses Are Deductible***, earlier).

Swimming Lessons

See **Dancing Lessons**, earlier.

Weight-Loss Program

You cannot include the cost of a weight-loss program in medical expenses if the purpose of the weight control is to maintain your general good health. But you can include the cost of a weight-loss program undertaken at a physician's direction to treat an existing disease (such as heart disease).

Can I "opt out" of Miscellaneous and Prescription Medicine Benefits?

Yes. Under the Affordable Care Act, accounts like the Miscellaneous and Prescription Medicine Benefits Accounts are required to allow you to opt out permanently at least annually and when employment ends. This is because some plans allow people to continue to receive reimbursement after eligibility for basic benefits ends, and that coverage will disqualify the person from tax credits and other advantages of buying individual Marketplace coverage. You can permanently opt out of Miscellaneous and Prescription Medicine Benefits at any time by filing a written election with the Plan Administrator. However, you should only need Marketplace coverage if and when your coverage under the Plan ends, and because Miscellaneous and Prescription Medicine Benefits will cease whenever your eligibility for coverage by the Plan ends, you should not need to opt out of or waive these benefits to become eligible for the advantages of Marketplace coverage.

SECTION 11

INDIVIDUAL HEALTH REIMBURSEMENT ACCOUNT

Who is eligible for an Individual Health Reimbursement Account?

Currently, only Building Trades and Gas Distribution Members are eligible. If you are not working in the Building Trades or Michigan or Ohio Gas Distribution classifications, this section does not apply to you.

What is the Individual Health Reimbursement Account?

Each month in which you are eligible for Basic Benefits, an Employer contribution for each hour you work will be credited to an Individual Health Reimbursement Account under the separate Individual HRA Plan and Trust for your benefit. You can use this to:

- Pay your self-pay contributions to maintain coverage under this Plan if your hours are reduced below the 100-hour monthly minimum for any reason (layoff, unemployment, reduced hours, disability, or retirement); or

- Pay for other medical coverage for you, your Spouse or Children after retirement (for example, Medicare premiums); or

- Pay expenses otherwise eligible under Miscellaneous Benefits for you, your Spouse or Children once your Miscellaneous Benefits for the year have been used up.

This Account is intended primarily as a way to help pay for part of your medical expenses in retirement. **If possible, you should use it before retirement only as a last resort.**

How will the amount in my Individual Health Reimbursement Account be determined?

The Administrative Manager maintains Account records for each eligible Participant. Contributions are credited to this Account each month and amounts paid from the Account are subtracted each month. The monthly status report that you currently receive will show any additional contributions to the Account for the month and will reflect the total unused amount in the Account as of the end of the month. The monthly status report will not show details of each expense paid for the month. You will receive an annual status report that will show complete detail for the entire year.

Will the Individual Health Reimbursement Account be credited with investment income, losses and administrative expenses?

Yes. Whatever part of the Individual Health Reimbursement Account is not used will be carried forward and will accumulate earnings or have losses subtracted from it. Administrative expenses will also be charged against all Accounts. The Trustees invest these funds separately from the rest of the Health and Welfare Plan assets. Earnings and losses are only credited to or subtracted from the Account at the end of the Plan Year, and are shared based on the amount in the Account on the last day of the Plan Year. So any amounts withdrawn from the Account during the year will not share in the earnings. Expenses may be subtracted on a per account basis or as a percentage of Account assets, depending on the type of expense.

Unused amounts and earnings carry forward from year to year and grow tax-free to help cover medical costs after retirement. **Because of the tax-free growth of this Account, it is always better to pay your self-payments and other expenses directly so you can accumulate the maximum amount to help pay for medical expenses in retirement.**

Are amounts paid from the Account subject to income tax?

No. The Account funds are held in the tax-exempt Health Fund, and amounts used to pay self-payments, premiums, or medical expenses are not included in your taxable income.

Can I use the Individual HRA to pay co-pay amounts (and co-insurance amounts under Standard Coverage)?

Yes. Co-payments and co-insurance on Basic Benefits that are not eligible under the Miscellaneous Benefit will be eligible under the Individual HRA Benefit and any expenses incurred at a physician's office, hospital or with another health care provider will be assumed to be deductibles, co-payments (and co-insurance under Standard Coverage) and will be deducted from any remaining balance in your Individual HRA account.

Because the Miscellaneous Benefit will pay Delta Dental co-pays as an exception to the general rule, the Individual HRA may be used to pay co-pays under the Delta Dental benefits under the Health and Welfare Plan once the Miscellaneous Benefits have been exhausted for the claim year.

In what situations may my Individual HRA account be depleted when I use the Benefit Advisor Card even though I have Miscellaneous Benefits left?

When you use your Benefit Advisor Card to pay for services rendered by a Nonparticipating Provider, since the expense is coded as a medical expense, and is not a prescription medicine, dental or vision expense, your Individual HRA balance will be used before your Miscellaneous Benefits. If you wish to use your Miscellaneous Benefits instead, you may submit amounts charged for services provided by Nonparticipating Providers to the Fund Office for manual processing. You should only submit Nonparticipating Provider balance billings to the Fund Office for manual processing; all deductibles and co-pay amounts (and co-insurance under Standard Coverage) may only be reimbursed by using the Benefit Advisor Card.

How do I use the Individual HRA to pay my self-pay amounts?

Contact the Administrative Manager to obtain an Individual HRA Reimbursement Request Form. Fill out the form and send it to the Administrative Manager, asking to have the self-pay amounts taken from the Individual HRA. This will <u>not</u> happen automatically.

The Administrative Manager will assume that you want to save the Individual HRA for use later in retirement and will expect you to make your self-payment directly unless you elect in writing to use the Individual HRA for self-payments.

How do I use the Individual HRA to pay for eligible expenses after my Miscellaneous Benefits are used up?

Once your Miscellaneous Benefits are used up, eligible expenses will be automatically deducted from the remaining balance in your Individual HRA. This will happen when you use your Benefit Advisor Card (with your BCBSM Card for prescriptions). For providers that do not accept VISA, after you have paid an expense that is eligible for reimbursement, contact the Administrative Manager to obtain an Individual HRA Reimbursement Request Form. Fill out the form and send it to the Administrative Manager. You will be asked to submit proof supporting the type of expense incurred and proof of payment. After processing the request, the Administrative Manager will send you a reimbursement check.

What happens when the Individual HRA runs out of money?

If you are still actively working in an eligible classification, new contributions will be added as you work more hours. If you are retired, there will be no more benefits available once the Individual HRA is used up.

What if there are funds left in my Individual HRA when I die?

Whatever is left in your Individual HRA can continue to be used by your Spouse and Children for self-payments or eligible expenses. If there is nobody eligible to continue to use these benefits, then at the end of the year in which nobody is eligible, the remaining balance will be added to Individual HRA income for the year and allocated together with all other income to all accounts eligible for income allocations.

What happens to Individual HRA balances when transfer to another Health Care Fund is requested under reciprocity?

If you request a transfer of your Individual HRA contributions under a reciprocity agreement with another Fund, your Individual HRA will be transferred to the other Fund in accordance with the reciprocity agreement. Any Individual HRA funds not accepted by the reciprocal Fund will be forfeited and allocated to other Individual HRAs at the end of the Plan Year as additional earnings.

What happens when Individual HRA balances become too small to administer?

To keep the costs of administering the Fund reasonable, the Individual HRA of a Participant who is not Actively at Work will be cancelled at the end of the Plan Year if the Individual HRA has become too small to provide any significant benefit. An Individual HRA is considered too small to provide any significant benefit if its balance at the end of the Plan Year, before allocating income for the year, is less than $75.00. Any funds from Individual HRAs cancelled under this rule will be forfeited before income is allocated for the Plan Year. The forfeited amount will be allocated to other Individual HRAs at the end of the Plan Year as additional earnings.

What happens to my contributions when I am not eligible for Basic Benefits?

When you are not covered under Basic Benefits, new Employer contributions cannot be credited to your account. Instead, they will be segregated in a separate bookkeeping account ("suspended contribution credits"). If you become eligible or re-eligible for Basic Benefits coverage (by earning 520 hours of credit in a 12-month period) before those credits are reallocated to other Participants, those credits will be credited to your Individual HRA as of the first day of your first month of new Basic Benefits coverage. If you do not regain Basic Benefits eligibility, your suspended contribution credits will be treated as earnings and will be reallocated to other Participants' Individual HRAs as of each May 31, but only if you are not eligible at that time and your ineligibility has lasted 12 consecutive months or more. (Note that when you lose eligibility, you can continue to submit claims to use your remaining balance; the suspension only applies to new contributions.)

Can I "opt out" of Individual HRA coverage?

Yes. Under the Affordable Care Act, accounts like the Individual HRA are required to allow you to opt out permanently at least annually and when employment ends. This is because when you lose eligibility, you can continue to submit claims to use your remaining balance. The right to keep submitting for reimbursement may disqualify you from tax credits and other advantages of buying individual Marketplace coverage. You can permanently opt out of the Individual HRA at any time by filing a written election with the Plan Administrator.

SECTION 12

LIFE INSURANCE DEATH BENEFIT

Does my family receive a Life Insurance Death Benefit if I die as a Participant?

If at the time of death you are not retired and are either (a) an Actively at Work Participant, or (b) covered under the Plan by making self-payments, your named Beneficiary is entitled to a Life Insurance Death Benefit. For this purpose, a member who is making self-payments while Totally and Permanently Disabled will not be treated as "retired" until attaining age 60, even if drawing Disability Retirement Benefits under the UA Local 190 Pension Plan. At the time of death, the Administrative Manager's Office should be contacted promptly so that necessary forms and instructions for filing a Life Insurance Death Benefit claim may be furnished to the named Beneficiary. Life Insurance Death Benefits are applicable to those persons who meet the eligibility rules on the date of death. Written notice of the death of an eligible Participant must be given to the Administrative Manager's Office within 90 days of the date of death of the Participant; otherwise no Life Insurance Death Benefit will be payable. Effective for deaths occurring on or after August 1, 2012, the Life Insurance Death Benefit is $15,000.

Effective December 1, 2015, you may apply and pay for optional supplemental group term life insurance coverage through MetLife for yourself, your Spouse and your Children (with the requirement that your Children be between 15 days and 26 years old and supported by you) in the amounts described below:

For You: $25,000 to $100,000 in $25,000 increments ($25,000 minimum and $100,000 maximum)

For your Spouse: $5,000 increments to a maximum of $20,000, not to exceed 50% of your supplemental life insurance coverage benefit amount

For your Children:	For a Child 15 days to 6 months old:	$ 1,000
	For a Child more than 6 months old, the following options:	$ 1,000
		$ 2,000
		$ 4,000
		$ 5,000
		$10,000

Effective December 1, 2015, you may apply and pay for optional, supplemental individual whole life insurance coverage through Texas Life Insurance Company for yourself, your Spouse, your Children and your grandchildren in the amounts described below*:

For You (if you are aged 17-70):

Minimum, initial face amount: ages 17-49 $10,000; ages 50-70 $5,000

Guaranteed Issue (Tier 1) maximum initial face amount: $75,000 ages 17-39; $50,000 ages 40-49; $25,000 ages 50-59; $15,000 ages 60-70

Express Issue (Tier 2) maximum initial face amount: $150,000 ages 17-39; $100,000 ages 40-49; $50,000 ages 50-59; $30,000 ages 60-70

Simplified Issue (Tier 3) maximum initial face amount: $250,000 ages 17-70

For your Spouse (age 17-70):

Minimum, initial face amount: ages 17-49 $10,000; ages 50-70 $5,000

Guaranteed Issue (Tier 1) maximum initial face amount: N/A

Express Issue (Tier 2) maximum initial face amount: $50,000 ages 17-49; $25,000 ages 50-59; $10,000 ages 60-70

Simplified Issue (Tier 3) maximum initial face amount: $75,000 ages 17-49; $50,000 ages 50-59; $25,000 ages 60-70

For your Children (ages 15 days-26 years) and
For your grandchildren (ages 15 days-18 years):

Minimum only, initial face amount: $10,000

*Spouses, Children and grandchildren are eligible regardless of whether the corresponding employee applies for coverage. Policies for Spouses, Children and grandchildren are not available in all states.

The optional, individual whole life insurance coverage through Texas Life Insurance Company is individually underwritten and rates are guaranteed.

Initial face amount: Prior to age 65, or if 20 or fewer years have elapsed from the date coverage was purchased if it was purchased after age 45, the death benefit is equal to the initial face amount. Upon the insured's death, the insured's beneficiary will receive the death benefit if all policy requirements are met.

Neither of these optional, supplemental life insurance options are available to Retirees.

May I convert my Life Insurance Death Benefit if I retire or terminate my covered employment?

If you retire or terminate your work under the Local 190 jurisdiction, cease to be in an eligible class, the group policy ends (provided you have been insured for life insurance for at least five continuous years) or if the group policy is amended to end all life insurance for an eligible class of which you are a member (provided you have been insured for at least five continuous years),you may convert the standard Fund-provided life insurance coverage to an individual policy of life insurance within 31 days without medical examination. **Your insurance does not continue unless you convert it**. You should ask for a conversion application form as soon as possible. If you are given written notice of the option to convert within 15 days before or after the date your life insurance ends, the application period begins on the date that such life insurance ends and expires 31 days after such date. If you are given written notice of the option to convert more than 15 days after the date your life insurance ends, the application period begins on the date such life insurance ends and expires 15 days from the date of such notice. In no event will the application period exceed 91 days from the date your life insurance ends. Conversion coverage is also contingent on any other requirements of the current insurer.

The amount of the conversion policy will not exceed the amount provided under the group Plan. If your life insurance ends due to the end of the group policy or amendment of the group policy ends all life insurance for an eligible class of which you are a member, the maximum amount of insurance that you may elect for the new policy is the lesser of: 1) the amount of your life insurance that ends under the group policy less the amount of life insurance for which you become eligible under any group policy within 31 days after the date insurance ends under the group policy; or 2) $10,000. If your life insurance ends due to the Plan sponsor's restructuring, the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance that ends under the group policy less the amount of life insurance for which you become eligible under any other group policy within 31 days after the date insurance ends under the group policy. If your life insurance ends for any other reason, the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance which ends under the group policy. You may choose any type of individual policy except term insurance then being written by the carrier the Plan then has. The premium cost to you will be based upon the insurer's rate then in use, the form and amount of insurance for which you apply, your class of risk and your age at the time of conversion. Contact the Administrative Manager's Office well in advance if you wish to have this coverage.

For any supplemental group term life insurance coverage you may have purchased, if you retire, the group policy ends, you cease being eligible under the group policy, you fail to pay the premium or fail to make required self-payments under the Plan for any month in which you work less than 100 hours, (provided you have been insured for such coverage for at least five continuous years), you may convert a portion of your coverage to an individual policy of life insurance if you complete and provide MetLife a conversion application within 31 days after your life insurance ends (if you are given written notice of the conversion option within 15 days before or after the date your life insurance coverage ends) or within 15 days after the date you are given written notice of the option to convert that is more than 15 days after the date your life insurance ends (but in no event may the application be provided more than 91 days from the date your life insurance ends).

For dependent (for your Spouse and dependent Children) supplemental group life insurance coverage purchased at your own expense, if you retire, the group policy ends (provided you have been insured for life insurance for the dependent for at least 5 continuous years) or the group policy is amended to cease life insurance for dependents for an eligible class of which you are a member (provided you have been insured for life insurance for the dependent for at least 5 continuous years) you will have the option to convert life insurance for the dependent.

The dependent will have the option to convert when the life insurance for the dependent ends because the dependent ceases to be eligible as a dependent under the group policy or you die.

For conversion of dependent life insurance under either of the above two paragraphs, if written notice of the option to convert is given within 15 days before or after the date life insurance for the dependent ends, the application period begins on the date the life insurance ends and expires 31 days later. If written notice of the conversion option is provided more than 15 days after the date life insurance for the dependent ends, the application period beings on the date the life insurance ends and expires 15 days following date of the notice, and in no event will the application period exceed 91 days from the date the dependent life insurance ends.

Can I port my Life Insurance Death Benefit if I retire or terminate my covered employment?

For the optional supplemental group term Life Insurance Death Benefit coverage, there is an option to "port" a portion of your coverage upon your retirement, termination of employment, ceasing to be a member of a class that is eligible for the insurance, or if the portability option for this coverage ends, unless the insurance is replaced by similar insurance under another group insurance policy. "Porting" coverage means continuing group coverage under another group policy at group rates. MetLife maintains a separate pooled group for this purpose and rates may be lower under this option than under the conversation option.

The optional supplemental group Life Insurance Death Benefit coverage for you, your Spouse and your dependent Children is portability-eligible in maximum amounts that may be less than the original coverage. Porting may only be exercised via a written request within the following time limits: if written notice of the option to port is given within 15 days before or after the date insurance ends, the request period begins on the date the insurance ends and expires 31 days after that date. If written notice of the option to port is given more than 15 days but within 91 days of the date insurance ends, the request period begins on the date the insurance ends and expires 45 days after the date of the notice. If written notice of the option to port is not given within 91 days of the date insurance ends, the request period begins on the date the insurance ends and expires at the end of the 91 day period.

SECTION 13

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Is an Accidental Death and Dismemberment Benefit paid if I die accidentally or if I am dismembered?

Yes, this benefit (the basic Accidental Death and Dismemberment benefit covered by the Plan) is paid in addition to any other benefits that may be payable by the Plan and is not subject to Coordination of Benefits. You must be eligible by Employer contributions or self-payments and be an Actively at Work Participant, a Participant who is not Actively at Work who is covered under the Plan by making self-payments, or a Participant who is a Totally and Permanently Disabled Participant who is covered under the Plan by making self-payments at the time of the accident. Premiums can be waived for accidental death & dismemberment coverage if you are receiving a disability pension under the UA Local 190 Pension Plan, if you apply for disability premium waiver and it is approved by the current insurance carrier. If you retire, the standard Accidental Death and Dismemberment Benefit that is covered by the Fund is <u>not</u> available unless you convert your Life Insurance Death Benefit as described in Section 12.

The Accidental Death Benefit paid to your named Beneficiary in the event of your death as an active Member is $15,000 effective August 1, 2012. This is in addition to the Life Insurance Death Benefit, which for active Members, is also $15,000 effective August 1, 2012. This is an insurance benefit the Fund provides through purchasing a group policy that covers your life.

How much am I paid if I suffer dismemberment but don't die?

In the event you sustain any of the following losses through external, violent or accidental means, on or off the job, the indicated percentage of the Accidental Death and Dismemberment Benefit will be paid in addition to any other benefits payable under the Plan:

Loss of a combination of hand, foot, or sight of one eye or other combination as defined in the current insurance policy	100%
Loss of arm at or above the elbow or loss of leg at or above the knee	75%
Loss of hand at or above the wrist but below elbow Or loss of foot at or above the ankle but below the knee	50%

What are the rules for payment of the basic Accidental Death and Dismemberment Benefit?

The loss must occur within 12 months from the date of the accidental injury and be a direct result of the accidental injury, independent of other causes.

The loss of a limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the permanent and uncorrectable loss of sight in the eye; visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

In no event will more than the full amount of the Accidental Death and Dismemberment Benefit be payable.

Are there situations where the Accidental Death and Dismemberment Benefit will not be paid?

Yes. Payment of the Accidental Death and Dismemberment Benefit will not be made for death or any loss resulting from or caused directly, wholly or partly by:

- Physical or mental infirmity, or the diagnosis or treatment of such illness or infirmity;;

- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Participation in the committing or attempted committing of a felony;
- Most service in the armed forces of any country or international authority;
- Any incident related to travel in an aircraft other than as a passenger, and incidents related to travel in an aircraft for parachuting, jumping from an aircraft or experimental air travel or space travel;
- The voluntary intake or use by any means or any drug, medication or sedative, unless it is taken or used as prescribed by a Physician; or an "over the counter" drug, medication or sedative taken as directed;
- The voluntary intake or use by any means of alcohol in combination with any drug, medication or sedative;
- The voluntary intake or use by any means of poison, gas, or fumes;
- War, whether declared or undeclared, or an act of war, insurrection, rebellion or active participant in a riot; or
- Any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Do I have any other options for Accidental Death and Dismemberment benefits?

Yes. Effective December 1, 2015, if you obtain the optional supplemental group life insurance coverage, you will be enrolled in the optional supplemental group accidental death and dismemberment coverage. You must be eligible by Employer contributions or self-payments and be an Actively at Work Participant, a Participant who is not Actively at Work who is covered under the Plan by making self-payments, or a Participant who is a Totally and Permanently Disabled Participant who is covered under the Plan by making self-payments at the time of the accident.

The Accidental Death Benefit paid to your named Beneficiary in the event of your death is an amount equal to your supplemental group life insurance benefits.

How much am I paid if I suffer dismemberment but don't die?

In the event you sustain any of the following losses through external, violent or accidental means, on or off the job, the indicated percentage of the supplemental Accidental Death Benefit will be paid in addition to any other benefits payable under the Plan and under the optional, supplemental life insurance coverage options:

Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%
Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%
Loss of sight in one eye	50%

(Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.)

Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of the same hand	25%

(Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.)

Loss of speech and loss of hearing	100%
Loss of speech or loss of hearing	50%

(Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury. Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.)

Paralysis of both arms and both legs	100%
Paralysis of both legs	50%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%

(Paralysis means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.)

Brain Damage	100%

(Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all substantial and material functions and activities of normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persist for 12 consecutive months after the date of the accidental injury.)

Coma	1% monthly beginning on the 7th Day of the Coma for the duration Of the Coma to a maximum of 60 Months

(Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.)

Are there situations where the optional supplemental Accidental Death and Dismemberment Benefit will not be paid?

Yes. Payment of the optional supplemental group Accidental Death and Dismemberment Benefit will not be made for death or any loss resulting from or caused directly, wholly or partly by:

- Physical or mental infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;

- Intentionally self-inflicted injury;
- Participation in the committing or attempted committing of a felony;
- Most service in the armed forces of any country or international authority;
- Any incident related to travel in an aircraft other than as a passenger, and incidents related to travel in an aircraft for parachuting, jumping from an aircraft or experimental air travel or space travel;
- The voluntary intake or use by any means of any drug, medication or sedative, unless it is taken or used as prescribed by a Physician, or an "over the counter" drug, medication or sedative taken as directed;
- The voluntary intake or use by any means of alcohol in combination with any drug, medication or sedative;
- The voluntary intake or use by any means of poison, gas, or fumes;
- War, whether declared or undeclared, or an act of war, insurrection, rebellion or active participation in a riot; or
- Any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

May I convert or port my Accidental Death and Dismemberment Benefit?

There is no conversion or port option for the basic Accidental Death and Dismemberment Benefit.

There is an option to port a portion of the optional supplemental accidental death and dismemberment benefit (see the discussion of "porting" above). There is no option to convert any portion of the optional supplemental accidental death and dismemberment benefit.

SECTION 14

LOSS OF TIME BENEFITS

Can I get paid anything if I can't work because of an injury or sickness incurred off the job?

Yes. If, while covered, you become disabled to the extent you are unable to work because of a non-occupational Accidental Injury or sickness, then you will be entitled to receive a weekly benefit called Loss of Time Benefits, currently $300 a week. If you are injured on the job, you are covered by Workers' Compensation, and Loss of Time Benefits do not apply.

You must be eligible for coverage (either under the 100-hour rule or by having your self-pay status current) at the time you become disabled and at the time you file your claim. Claims must be filed no later than 60 days after you become disabled. See **Claim Procedure for Fund Coverages of Miscellaneous Benefits, Prescription Medicine Benefits, and Loss of Time Benefits** in **Section 21, Filing Claims And Appeals**.

For what period are benefits paid?

Benefits will begin as of the first day of disability due to an accident or as of the eighth day of disability due to sickness and will continue for any one period of disability up to 26 weeks. Benefits are payable on the basis of the normal five-day workweek. No benefits are payable during any period you are receiving pension benefits.

Successive disability periods separated by less than two weeks of continuous active employment are considered as one continuous period of disability unless they arise from different and unrelated causes.

You do not have to be confined to your home to collect benefits, but you must be under the care of a physician. No disability will be considered as beginning more than three days prior to the first visit of or to a physician.

What if my injury is incurred on the job?

This Loss of Time Benefit does not apply if you suffer an occupational injury. In that case the Plan does not cover you, and your costs are handled under a Workers' Compensation procedure.

However, you may also receive a benefit if you are dismembered, even on the job. See **Section 13, Accidental Death and Dismemberment Benefit**.

NOTE: This benefit is not available to retirees.

SECTION 15

PRE-EXISTING CONDITIONS

Exclusion Period

What are some of the special rules regarding my coverage if I had treatment for an illness before I had Plan coverage?

A pre-existing condition is any physical or mental condition, except pregnancy, for which medical advice, diagnosis, care or treatment was recommended or received from a licensed care giver within the six-month period ending on the date of your hire from which your 520 hours of covered employment was calculated.

Before January 1, 2014, you would have to wait 90 days in order to have a pre-existing condition covered. Effective January 1, 2014, this rule no longer applies.

SECTION 16

MEDICAL CARE OUTSIDE OF THE UNITED STATES

What if I receive medical services outside of the United States?

The Basic Benefits provided by the Blue Cross Blue Shield program cover services outside the 50 states, but only through the claim procedure described in Section 21, Filing Claims and Appeals. See that section for specifics of how to file a claim. In these cases, Blue Cross Blue Shield will pay reimbursement to you in accordance with its own schedules. You may not be reimbursed for your entire bill. Reimbursement will be based on what is reasonable and customary in the area where services are rendered.

Except for emergency treatment, you must have prior approval from the Trustees for elective care outside the U.S. The Fund will not pay transportation or accommodation expenses.

SECTION 17

MEDICARE, SUPPLEMENTAL COVERAGE, AND END STAGE RENAL DISEASE (ESRD)

Are retirees covered by the Plan?

Effective June 1, 2015, Medicare-Eligible Retirees (retirees age 65 or older) are covered by the UA Local 190 Medicare Retiree Health and Welfare Plan, a separate plan which is identical to the UA Local 190 Health and Welfare Plan covering active employees with the exception that prescription medicine expenses for those Members will not count toward the TrOOP annual out-of-pocket limit. All other retirees are covered by the UA Local 190 Health and Welfare Plan.

If you return to work following retirement and you are a Medicare-Eligible Retiree, your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan terminates and you become covered under the UA Local 190 Health and Welfare Plan immediately upon your return to work, without having to complete a new period of 520 hours of covered employment. Once you stop working, your coverage under the UA Local 190 Health and Welfare Plan terminates and your coverage under the UA Local 190 Medicare Retiree Health and Welfare Plan resumes.

Medicare Coverage

What is Medicare?

Medicare is a federal health care program designed to provide health care benefits to persons aged 65 and older 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 End Stage Renal Disease (ESRD). However, you are eligible to 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, or you will be required to pay extra premiums for your Medicare insurance.

Medicare coverage has three parts: hospital insurance Part A, medical insurance Part B and prescription coverage Part D. Part A helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Part B medical insurance helps pay for physician's services and other medical services and items. Part D helps pay for the cost of prescription medications.

The Part A hospital insurance portion is provided by the government at no cost to you. However, you must pay monthly for the Part B medical portion and the Part D prescription portion. These premiums are adjusted annually. You will be notified of the change in premium for the part B by the Social Security Administration before each new year.

Employed Persons Aged 65 or Older

What if I am still employed when my Spouse or I reach age 65?

When you reach 65 and become eligible for Medicare, but are still working, the Fund continues as your primary health care plan, and Medicare becomes your secondary health care plan.

Important: Even though you continue to be covered by your group plan as your primary plan, you should still apply for Medicare benefits, especially Part A and Part D.

- Part A of Medicare, the hospital insurance, is offered without cost to you. It may provide additional benefits to your group coverage.

- Part B of Medicare, the medical insurance, is also available. However, because you pay for this coverage, you can delay enrollment in Part B without penalty **as long as you are covered by our Plan**.

- Part D of Medicare, the prescription medication insurance, is also available. The Prescription Medicine Benefit coverage under the Plan is not expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because it is not as beneficial as Medicare Part D, it is considered "non-creditable coverage." This means that it is to your benefit to enroll in a Medicare Part D prescription drug plan as soon as you are eligible. If you do not join a Medicare prescription drug plan as soon as you are eligible, you will have to pay more for the Medicare Part D prescription coverage when you lose coverage under the Plan or decide to leave the Plan. You will pay that higher premium as long as you have Medicare prescription drug coverage.

If you delay enrolling for Medicare Part B coverage when you reach age 65 because you are still covered by our Plan, 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.

In most cases, (other than in the case of prescription medication coverage) the Fund's benefits are more generous for an employed person than those provided under Medicare. Where they are not, you retain the right to file your claims with Medicare for whatever additional coverage is available.

Any time after the age of 65 that you cease to meet the definition of an Actively at Work Participant, Medicare becomes your primary payer, and you are then entitled to apply for Supplemental Coverage, described below. **You should immediately apply for Medicare Part B coverage when you cease being an Actively at Work Participant** – failure to do so will cause you to pay a substantial penalty on your lifetime Medicare Part B premiums once you do enroll.

Blue Cross Blue Shield Supplemental Coverage For Participants On Medicare

What if I am retired when I reach age 65?

It is assumed by the Plan that any retired person who is entitled to Medicare has all Medicare benefits, including Part A and Part B, and any replacements thereof. Therefore, this Plan will pay benefits for retired Participants and their Spouses and Children only after coverage paid by Medicare, or after coverage for which Medicare should have paid, regardless of whether you have the coverage or not. Be sure that you obtain both Medicare Part A and Part B coverage.

If you wish more coverage than that offered you by Medicare, you may get Supplemental Coverage, which you may acquire on a self-pay basis. Supplemental Coverage works with Medicare to extend your health care benefits. The coverage works as follows:

As a Medicare-Eligible Retiree, your prescription medicine expenses will not count toward the TrOOP annual out-of-pocket limit.

Supplement to Medicare Program

If you are retired when you reach age 65, you are eligible for the Blue Cross Blue Shield Supplemental Coverage if:

- You are a Participant in the Plan at the time you reach age 65, and

- You are eligible to receive monthly benefits from the UA Local 190 Pension Fund.

If you are eligible, other rules apply as follows:

- You must have both **Medicare Part A and Part B** coverage if you wish to have all available coverage. The Fund pays supplemental benefits as if you had the Medicare Part A and Part B coverage. A copy of your Medicare card and/or your Spouse's Medicare card must be submitted.

- You must be a Member in good standing with Local 190. Status will be checked when you are added to the program and will be checked each month thereafter.

- Coverage is available only when Employer contributions have terminated.

- You and/or your Spouse are eligible to be added on the first day of the month you and/or your Spouse become eligible for both Medicare Part A and Part B coverage.

- Your Spouse is eligible to be added to this program only if you meet the above requirements. In addition, as above described to get full coverage, you must be maintaining coverage for yourself under one of the retired Participant Self-Payment Programs. Your Spouse must have both Medicare Part A and Part B coverage. Your Spouse must elect to be covered under the Plan when you retire; otherwise your Spouse becomes ineligible.

- You must elect this coverage when it first becomes available to you. You cannot retire, drop our Plan, and later try to add it back without first becoming an Actively at Work Participant and working the required amount of hours.

- As a Medicare-Eligible Retiree, your prescription medicine expenses will not count toward the TrOOP annual out-of-pocket limit.

Schedule of Benefits

What coverage is provided?

The Supplement to the Medicare Program is designed to make sure that individuals covered by Medicare will have the same amount covered by the Plan as would be the case for an Active Participant who was not covered by Medicare. In other words, in most cases the Plan pays the portion that is not paid by Medicare and would have been paid by the Plan if you were Active.

If your provider has agreed to accept the Medicare approved amount as full payment for a service, this means that a claim for that service is an Assigned Claim. If your provider has not agreed to accept the Medicare approved amount as payment in full for a service, this means that a claim for that service is an Unassigned Claim.

If you receive a service for which the claim is an Assigned Claim, Blue Cross Blue Shield will not pay any amount towards the claim, since the provider has agreed to accept the Medicare provided amount. If you receive a service for which the claim is an Unassigned Claim, Blue Cross Blue Shield will pay the difference between the Medicare approved amount and the amount Blue Cross Blue Shield normally pays for covered services as if you were an Actively at Work Participant.

For Unassigned Claims, Medicare pays you the Medicare approved amount and Blue Cross Blue Shield pays you the difference between the Medicare approved amount and the amount approved by Blue Cross Blue Shield, if any. You are responsible for paying the provider’s charge. The provider may charge you more than the Medicare or Blue Cross Blue Shield approved amounts, and you will be responsible for paying the provider the difference between the Medicare approved amount and the Blue Cross Blue Shield approved amount.

For services provided out of state, covered benefits will vary based upon whether the provider participates with a Blue Cross Blue Shield plan and whether the provider accepts Medicare assignment. See the **Benefit Schedule. A free copy of the detailed Benefit Schedule is available from the Administrative Manager on request.**

Regardless of what Medicare pays, Blue Cross Blue Shield will not pay for anything that would not be covered if you were an Actively at Work Participant.

If Medicare does not cover a specific service or supply, Blue Cross Blue Shield will cover such service or supply if it is a covered benefit for a Member without Medicare.

All benefits provided under the Supplement to Medicare Program are subject to the Coordination of Benefits (COB) provisions as described in Section 22, Coordination of Benefits and Subrogation, of this SPD.

The above is a summary of benefits. Medicare benefits are subject to final interpretation of the Department of Health and Human Services.

Miscellaneous Benefits

In addition to the Supplemental Coverage provided by Blue Cross Blue Shield, will the Fund continue to pay vision and dental and other Miscellaneous Benefits?

Yes, the Fund will continue to pay the same Miscellaneous Benefits it paid for you as an Actively at Work Participant, except for Loss of Time Benefits, Accidental Death and Dismemberment Benefits and Life Insurance Death Benefits.

The Trustees always retain the right to change this and any other benefit under the Plan.

Method of Payment for Coverage

Will premiums for Supplemental Coverage be deducted from my pension Benefit?

Yes. You as a retired Participant will have self-payments deducted from your UA Local 190 Pension Fund benefit check. If your self-pay coverage is terminated, cancellation of the deductions must be made in writing at least 60 days before the effective date of cancellation.

How do I pay for Supplemental Coverage if for some reason it can't all be deducted from my pension Benefit?

Please see **Section 19, Self Pay Rules**, which apply to your self-pay requirement.

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 Administrative Manager's Office.

Provisions for Continued Participation

How do I continue Supplemental Coverage?

You as a retired Participant may continue your coverage under the Supplement to Medicare Program for yourself until one of the following occurs:

- You fail to remit self-payments on time or in the proper amount.
- You fail to remain a Member in good standing with Local 190.
- The termination of the Supplement to Medicare Program.
- The death of the retired Participant. In the event of your death, your Surviving Spouse may continue coverage under either the Surviving Spouse Self-Payment Program or COBRA Continuation of Coverage.
- You lose your Medicare coverage. If you lose your Medicare coverage, you must immediately notify the Administrative Manager's Office to make arrangements for continued coverage under the appropriate Self-Payment or Actively at Work Participant Program, provided you meet the qualification for participation in one of those programs. Coverage may also be provided under COBRA Continuation of Health Coverage.

Coverage may be continued for your eligible Spouse and Children under the Retiree Self-Payment Program. The rules for continuation of coverage for your Spouse and Children are the same as for continuation of coverage as a retired Participant. See **Section 19, Self Pay Rules**.

End Stage Renal Disease

If I have End Stage Renal Disease (ESRD), how does the Plan coordinate with my Medicare coverage?

We will coordinate our payment with Medicare for all covered services used by Members with ESRD, including hemodialysis and peritoneal dialysis. Therefore, it is important that Members with ESRD file a valid application for Medicare with the Social Security Administration. Dialysis services must be provided in a hospital, a participating freestanding ESRD facility or in the home.

When Medicare Coverage Begins

For Members with ESRD, Medicare coverage begins the first day of the fourth month of dialysis, provided you file a valid application for Medicare with the Social Security Administration.

Example: Dialysis begins February 12. Medicare coverage begins May 1.

The period before Medicare coverage begins (up to three months) is the Medicare waiting period.

If you begin a self-dialysis training program in the first three months of your regular course of dialysis, the Medicare waiting period is waived. In this case, Medicare coverage begins on the first day of the month in which you begin your regular course of dialysis.

If you are admitted to a Medicare-approved hospital for a kidney transplant or for related health care services you need prior to a transplant, Medicare coverage begins on the first day of the month in which you are admitted to the hospital. Your transplant must take place that month or within the following two months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or for related health care services you need prior to the transplant, Medicare coverage begins two months before the month of your transplant.

When Blue Cross Blue Shield Coverage is the Primary or Secondary Plan

If your Blue Cross Blue Shield group coverage is provided through an employer and you are entitled to Medicare because you have ESRD, your Blue Cross Blue Shield coverage is your primary plan for all covered services for up to 33 months, which includes the three-month (maximum) waiting period and the 30-month coordination period. (A medical evidence report may be used to establish the coordination period.) After the 30-month coordination period ends, Blue Cross Blue Shield is your secondary plan and Medicare is your primary plan.

Dual Entitlement

If you have dual entitlement to Medicare **and** have employer group health plan benefits, the following conditions apply:

- If entitlement based on ESRD occurs at the same time as or prior to entitlement based on age or disability, the plan provided by the employer group is the primary plan through the end of the 30-month coordination period.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. You start a regular course of dialysis on June 12, 2011, and on September 1, 2011, you become entitled to Medicare because you have ESRD. In February 2012 you become entitled to Medicare because you turn 65. In this situation, even though you turn 65 during the 30-month coordination period, your employer's plan will be your primary plan for the entire 30-month coordination period from September 1, 2011, through February 2014. Your employer's plan will be your secondary plan starting March 1, 2014.

- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:

- If you are a working aged or working disabled individual in your first month of dual entitlement, the plan provided by your employer group is your primary plan and remains your primary plan through the end of the 30-month coordination period. Because you are working and not a retiree, although you are Medicare-eligible, your prescription medicine costs will count toward the TrOOP annual out-of-pocket limit.

Example: You became entitled to Medicare in June 2011, when you were 65 years old. You have coverage through your employer's plan and, because you are still working, your employer's plan is your primary plan. On May 27, 2013, you are diagnosed with ESRD and begin a regular course of dialysis. On August 1, 2013, you become entitled to Medicare because you have ESRD. Your employer's plan remains your primary plan for the 30-month coordination period, from August 1, 2013, through January 31, 2016. Medicare becomes your primary plan on February 1, 2016. Because you are not a retiree, your prescription medicine costs will count towards the TrOOP annual out-of-pocket limit.

- If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. In August 2011, when you turn 65, you become entitled to Medicare. In January 2012 you begin a regular course of dialysis. On April 1, 2012, you become entitled to Medicare because you have ESRD. Because Medicare was already your primary plan when you became dually entitled, Medicare will remain your primary plan both during and after the coordination period.

SECTION 18

PREAPPROVAL AND PRECERTIFICATION

If I have to go into the hospital and/or have surgery, do I have to find out what my hospital and surgeon will charge or get a second opinion or prior Trustee approval to make sure my coverage will pay the bill?

If you are using a participating provider for Basic Benefits, the doctor has agreed in advance to the payment to be made by Blue Cross Blue Shield, and the doctor cannot bill more. However, if you are not using a participating provider, then Blue Cross Blue Shield will only pay what it determines is the fair price for the service in the geographic area of the service. If this is less than the doctor charges, which it usually is, then the Fund will pay up to its reasonable and customary limits. After that, you will be responsible for the balance. You no longer have to get a second opinion or prior approval of the Trustees for Basic Benefits.

Under this Plan, precertification is generally required only if you enter an inpatient long-term acute care hospital or use a noncontracted hospital under certain circumstances. This is explained in Section 8, Health Care Coverage - Basic Benefits. For more information on these precertification requirements, see the **detailed Benefit Schedule** available upon request from the Administrative Manager at no cost to you, or contact your Blue Cross Blue Shield customer service representative.

Preapproval may be required to be obtained by your provider for certain procedures or items of coverage. A participating provider is aware of which items require preapproval at the provider level and is responsible for contacting Blue Cross Blue Shield when appropriate.

You always have the right to obtain whatever health care you and your health care provider decide is best for you. Blue Cross Blue Shield and the Trustees have the right only to determine what will and will not be paid under the coverage provided by this Plan.

Do medicines administered by providers require pre-approval?

Medications on Blue Cross Blue Shield's select specialty pharmaceutical list will be covered by the Plan as a Basic Benefit only if the medication is **pre-authorized**. These are a select group of medicines administered by injection or infusion in a physician's office, a clinic, or a patient's home. Pre-authorization is a method of managing the use of these medicines and making sure they are used only when use is appropriate under Blue Cross Blue Shield criteria. This means that your physician or other professional provider must contact Blue Cross Blue shield in advance of the medicine's administration and obtain Blue Cross Blue Shield's approval. Blue Cross Blue Shield establishes specific criteria that must be met before approval will be granted. The criteria vary from medication to medication, and are designed to make sure that these specialty pharmaceuticals are administered only in appropriate cases.

Are there any pre-approval requirements for prescription medicines?

In some cases, BCBSM may require your physician to seek pre-approval before filling prescriptions for certain medications. If the pre-approval is denied, an alternative prescription medicine or therapy may be offered. If BCBSM denies coverage for a particular medicine, the Fund generally will not pay for that medication.

If you have any questions regarding pre-approval requirements for prescription medicines, call BCBSM at the number shown at the end of this document.

SECTION 19

SELF PAY RULES

This is a summary only. You must look to the detailed description of self-pay eligibility rules of Sections 2 through 6 for the specifics of eligibility. Monthly self-pay premiums may be changed by the Trustees effective before you receive a new SPD. Contact the Administrative Manager for current rates.

Eligibility Group	**Period Eligible**	**Coverage**	**Monthly Self Pay Premium ***
Bargaining unit employee participant	If on out of work list, 12 months at reduced rate (initial 12 month period counted against total 18 or 36 month "COBRA" coverage period). If not on out of work list, see "COBRA" Eligibility Groups, below.	Full Medical and Dental per Plan, Life Insurance, Misc. Benefits, Loss of Time	$100.00 per month
Bargaining unit employee participant	After first 12 month period expires (see above), 6 or 24 months (the remaining "COBRA" coverage period) at full "COBRA" rate unless Special Exception to Full COBRA rate applies. See "COBRA" Eligibility Groups, below, for applicable full "COBRA" rate.	Full Medical and Dental per Plan, Misc. Benefits	See COBRA Monthly Self Pay Premium, below, for Eligibility Group (single, couple, family)
Non-bargaining unit employee	Ineligible for self-pay except under "COBRA" Continuation. See "COBRA" Eligibility Groups, below, for applicable full "COBRA" rate.	N/A	N/A
Surviving Spouse, with family **	Indefinite	Full Medical and Dental per Plan, Misc. Benefits	$439.66 per month***
Surviving Spouse, without family **	Indefinite	Full Medical and Dental per Plan, Misc. Benefits	$320.31 per month***
Retiree, before age 60:	To age 60	Full Medical and Dental per Plan, Misc. Benefits	$531.01 per month ***
Retiree, before age 60, with Spouse on Medicare:	To age 60	Full Medical and Dental per Plan, Misc. Benefits	$457.93 per month ***
Retiree, age 60-65:	To age 65	Full Medical and Dental per Plan, Misc. Benefits	$405.56 per month***
Retiree, age 60-65, with Spouse on Medicare:	To age 65	Full Medical and Dental per Plan, Misc. Benefits	$326.39 per month***

Eligibility Group	Period Eligible	Coverage	Monthly Self Pay Premium *
Medicare Retiree (65 or otherwise) with Spouse not on Medicare, under Medicare Retiree Plan:	Indefinite	Supplemental Medical (Retiree), Full Medical (Spouse) and Dental per Plan, Misc. Benefits	$326.39 per month***
Medicare Retiree (65 or otherwise) with a family not on Medicare, under Medicare Retiree Plan:	Indefinite	Supplemental Medical (Retiree), Full Medical (Family) and Dental per Plan, Misc. Benefits	$405.56 per month***
Medicare Retiree, Medicare Spouse or Medicare Surviving Spouse only, under Medicare Retiree Plan:	Indefinite	Supplemental Medical, Dental per Plan, Misc. Benefits	$84.03 per month (each) ***
COBRA, full coverage, single	18 or 36 months	Full Medical and Dental per Plan, Misc. Benefits	$647.00 per month*
COBRA, full coverage, couple	18 or 36 months	Full Medical and Dental per Plan, Misc. Benefits	$1,425.00 per month*
COBRA, full coverage, family	18 or 36 months	Full Medical and Dental per Plan, Misc. Benefits	$1,846.00 per month*
COBRA, basic coverage, single	18 or 36 months	Full Medical per Plan, Misc. Benefits, No Dental	$626.00 per month*
COBRA, basic coverage, couple	18 or 36 months	Full Medical per Plan, Misc. Benefits, No Dental	$1,379.00 per month*
COBRA. basic coverage, family	18 or 36 months	Full Medical per Plan, Misc. Benefits, No Dental	$1,787.00 per month*
Participant on Workers' Compensation	First 12 months at indicated rate; Second 12 months at indicated rate; Third 12 months at indicated rate. All periods on Workers' Compensation run concurrently with and count against the total 18 or 36 month "COBRA" coverage period	Full Medical and Dental per Plan, Misc. Benefits	$100.00 per month for the first 12 months; $200.00 per month for the second 12 months; and $300.00 per month for the third 12 months.

Eligibility Group	Period Eligible	Coverage	Monthly Self Pay Premium *
Disabled Participant not receiving Pension Plan Disability	12 months at indicated rate (initial 12 month period counted against total 18 or 36 month "COBRA" coverage period) followed by 6 or 24 additional months (the remaining "COBRA" coverage period) at full "COBRA" rate, unless Special Exception to Full COBRA rate applies. See "COBRA" Eligibility Groups, above, for applicable full COBRA rate.	Full Medical and Dental per Plan, Misc. Benefits,	$100.00 per month for the first 12 months; COBRA Full Coverage rate thereafter
Disabled Participant not receiving Pension Plan Disability, following 12 months at reduced rate, only if special exception is granted by the Trustees	6 or additional 24 month period (the remaining "COBRA" coverage period) following initial 12 month period	Full Medical and Dental per Plan, Misc. Benefits	$100.00 per month
Disabled Participant receiving Pension Plan Disability and Social Security Disability	Duration of Pension Plan Disability	Full Medical and Dental per Plan, Misc. Benefits	Same as rates for Retiree (and spouse or family), age 65***
Disabled Participant receiving Pension Plan Disability, not on Social Security Disability, Single	Duration of Pension Plan Disability	Full Medical and Dental per Plan	$152.24 per month***
Disabled Participant receiving Pension Plan Disability, not on Social Security Disability, with spouse or family not on Medicare	Duration of Pension Plan Disability	Full Medical and Dental per Plan	$405.56 per month***
Disabled Participant receiving Pension Plan Disability, not on Social Security Disability, with spouse on Medicare	Duration of Pension Plan Disability	Full Medical and Dental per Plan	$326.39 per month***

* Subject to periodic review and change by Trustees; prices are as in effect March 1, 2016; however, COBRA rates will be adjusted each March 1 based on actual costs of coverage

** Surviving Spouse of either a Member or Non-Bargaining Unit Employee

*** Subject to increase on each March 1 following increase in single person basic coverage COBRA rate; increase determined by multiplying rate in effect by a fraction, the numerator of which is the new single person basic coverage COBRA rate and the denominator of which is the preceding year's single person basic coverage COBRA rate

Method of Payment for Coverage

If I have to make self-payments for coverage, how do I do it?

Self-payments are due in the Administrative Manager's Office on the last day of the month for which payment is being made. For example, if August hours are below the 100 required hours, the self-payment to provide coverage for the month of October is due in the Administrative Manager's Office no later than October 31.

Self-payments must be made by check or money order made payable to:

UA Local 190 Health and Welfare Fund

and sent to the Administrative Manager's address at the end of this document.

In addition, self-payments may be paid from your Individual HRA balance if you have sufficient funds available, but you must file an Individual HRA Reimbursement Request Form with the Fund Office before the self payment is due – this will not happen automatically. Note that you cannot use your Benefit Advisor Card to make self-payments.

If you are retired and are receiving a Pension Benefit, self-payments will be deducted from your UA Local 190 Pension Fund monthly benefit check.

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 Administrative Manager's Office.

Provisions for Continued Participation Under Self-Payment Programs

How long can I continue my coverage under self-payment provisions and how might my coverage be terminated?

As a self-pay Participant, subject to the eligibility periods listed above, you can continue your coverage under a Self-Payment Program until one of the following occurs:

- You fail to remit your self-payments on time or in the proper amount.
- You fail to remain a Member in good standing with Local 190.
- You attain age 65 or otherwise become eligible for Medicare benefits (in which case you may be eligible for Supplemental Coverage).
- The Trustees terminate the Self-Payment Program in which you are participating.
- You reach the end of the eligibility period for the Self-Payment Program in which you are participating.
- You otherwise become ineligible for the Self-Payment Program in which you are participating.

As a self-pay Participant, you may continue coverage for your Spouse and/or Children under this program until one of the following events occurs:

- You fail to remit your self-payment on time or in the proper amount.
- You fail to remain a Member in good standing of Local 190.
- You become eligible under Medicare, except that if your Spouse is not eligible for Medicare, you may continue coverage for your Spouse and any Children under the Self-Payment Program until they do become eligible for Medicare. Coverage may also be available under COBRA Continuation of Coverage.
- Your Child or Children no longer meet the definition of a Child under the Plan. You, as a self-pay Participant, your Spouse, or your Child must notify the Administrative Manager's Office, in writing, within 60 days following the date your child no longer qualifies as a Child in order to be offered COBRA Continuation of Coverage.
- The Trustees terminate the Self-Payment Program in which you are participating.

- You reach the end of the eligibility period for the Self-Payment Program in which you are participating.

- You otherwise become ineligible for the Self-Payment Program in which you are participating.

- Your Spouse no longer meets the definition of eligible Spouse. You, as a self-pay Participant, or your Spouse, must notify the Administrative Manager's Office, in writing within 60 days following the date your Spouse no longer qualifies as a legal Spouse in order to be offered COBRA Continuation of Coverage.

- Your death. In the event of your death as a self-pay Participant your Spouse and Children may continue coverage under either the Surviving Spouse and Children Self-Payment Program or COBRA Continuation of Coverage.

Note: If you retire, and you do not cover your Spouse at that time, you cannot add that Spouse later.

Special Provisions

What happens if I stop making my self-pay payments?

If you as a self-pay Participant decide to stop paying self-payments or you fail to pay your self-payment on time, 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 other than the COBRA notice, if applicable. You will not then have an opportunity to participate in the Plan under the Supplement to Medicare Program at the age of 65, unless you meet the qualifications of that program and the Trustees approve your coverage.

What if I return to work after being a self-pay Participant?

If you as a self-pay Participant return to active work at the trade for a covered Employer, you may continue to make self- payments under this program until you satisfy the eligibility provisions of the Actively at Work Program. It is your responsibility as a self-pay Participant to notify the Administrative Manager's Office, in writing, if you return to work and to again notify the Administrative Manager's Office, in writing, when you again retire or otherwise terminate your employment.

SECTION 20

COBRA CONTINUATION OF HEALTH COVERAGE

What if my* Spouse*, a Child, or I lose our health coverage?

Under a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, referred to as COBRA, you and your Spouse and Children may be able, as self-pay Participants, to continue your Basic Benefits for a period of time. (See **How long will coverage last?**) The benefits that can continue are only the medical, hospital, dental, Miscellaneous Benefits, Prescription Medicine, Individual HRA and EAP. You can't continue any other Benefits such as an Accidental Death or Dismemberment Benefit, Life Insurance Death Benefit or a Loss of Time Benefit.

If any of the events occur that terminate your eligibility for coverage under the Plan, and you or your Spouse or Children are covered at the time of the event as a Participant in the Plan, upon notice thereof to the Administrative Manager, you will receive a COBRA notice from the Administrative Manager. The Administrative Manager will then advise you specifically whether you are eligible, and if so, how to continue your Basic Benefits and certain Miscellaneous Benefits through COBRA. If the Administrative Manager determines that you are not entitled to elect COBRA continuation coverage, the Administrative Manager will advise you of why you are ineligible.

This section provides a summary of the law and therefore is general in nature. The law itself and regulations interpreting the law must be consulted with regard to the application of these provisions in any particular circumstance.

Am I entitled to COBRA even if I leave the trade?

Yes. This is a federal right given you.

Qualified Beneficiaries and Qualifying Events

Who is covered and after what events?

Participants. You have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment, termination of your employment (for reasons other than gross misconduct), or if you are retired, certain bankruptcy proceedings.

Spouses of Participants. Spouses of Participants covered by this Plan are "Qualified Beneficiaries," and have the right to choose continuation coverage for themselves if they lose group health coverage under the Plan for any of the following five reasons:

- The death of their spouse.
- Termination of their spouse's employment (for reasons other than gross misconduct) or reduction in their spouse's hours of employment.
- Divorce or legal separation from their spouse.
- Their spouse becoming entitled to Medicare (either Part A, Part B, or both, or Part D).
- The commencement of certain bankruptcy proceedings, if their spouse is retired.

Children. Children of Participants covered by this Plan also are "Qualified Beneficiaries" and have the right to continuation coverage if group health coverage under the Plan is lost for any of the following six reasons:

- The death of the Participant parent.

- The termination of the Participant parent's employment (for reasons other than gross misconduct) or reduction in the Participant parent's hours of employment.

- Parents' divorce or legal separation.

- The Participant parent becoming entitled to Medicare (either Part A, Part B, or both, or Part D).

- The Child ceasing to be a "Child" under the Plan.

- A proceeding in a bankruptcy reorganization case, if the parent who was a Participant is retired.

A Child born to, or placed for adoption with, the covered Participant during a period of continuation coverage also is a Qualified Beneficiary.

Separate elections. Each person who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a Spouse or Child is entitled to elect continuation of coverage even if the covered Participant does not make that election. Similarly, a Spouse or Child may elect a different coverage from the coverage that the Participant elects (for example, full coverage instead of basic coverage.

Elections

When must an election be made for COBRA continuation coverage?

Election Period. Election of continuation coverage must be made within 60 days of the later of the date coverage would terminate under the Plan due to the qualifying event or the date of the Qualifying Event Notice. If election of continuation coverage is not made within this 60-day period, you will lose your right to elect continuation coverage under COBRA.

Self-payment coverage is available under certain circumstances at rates lower than the full COBRA continuation coverage rate. This self-payment coverage counts against the total period of COBRA continuation coverage. To qualify for the lower rate, election of self-payment coverage must be made within certain time periods – generally by the 20th day of the month for which the first self-payment must be made. If this deadline is missed, COBRA continuation coverage at the full COBRA rate will still be available until the end of the 60-day election period described above.

EXAMPLE:

> Assume a Member works less than 100 hours in April. To qualify for the lower self-payment rates, the Member must pay the self-payment premium by June 20, the 20th day of the coverage month related to April hours. This deadline applies regardless of when notice is sent to the Member.
>
> Coverage is normally cancelled on June 1 under these circumstances if self-payment is not made. Assume that the date of the Qualifying Event Notice is May 5. Since the date coverage would terminate due to the 100-hour rule is June 1, even if the Member fails to elect the lower self-payment rate by June 20, the Member has until 60 days after June 1, or July 31, to elect continuation coverage under COBRA; but because the election was not made by June 20, the Member must pay the full COBRA continuation rate. If for some reason the date of the Qualifying Event Notice was later than June 1, the Member would have until 60 days after the date of the Qualifying Event Notice to elect continuation coverage under COBRA; but because the election was not made by June 20, the Member must pay the full COBRA continuation rate.

Payments

How much must I pay for COBRA coverage?

The Trustees determine the actual cost to the Plan that you must pay for COBRA coverage. COBRA rates are based on the actual expenses of the Plan and are adjusted annually. That is why they are higher than the rates under the other self-pay programs under the Plan. You should elect to participate in one of the self-pay programs described in **Section 19, Self Pay Rules**, if you are eligible.

When must payments be made for COBRA continuation coverage?

Due Date of First Payment. The first payment may, but need not be, sent with the Election Form. The first payment is due within 45 days of the date the election is made. You must make your first payment for continuation coverage not later than 45 days after the date or your election, or you will lose all continuation coverage rights under the Plan. You are responsible for making sure the amount of your first payment is correct according to the notice that is provided to you. The initial premium due will include payment for coverage from the time coverage is lost due to the qualifying event, through each subsequent month which has passed and through the month which has started by the time you make the initial payment.

Periodic Payments. All other premiums are due on or before the first of each month for that month's coverage period. A thirty (30) day grace period will be allowed for each monthly payment but if the premium is not received within thirty (30) days of the due date, all options, rights and benefits under this continuation provision and under the Plan will terminate automatically. There are no reinstatement privileges and no claim will be paid if it is incurred during any period for which premiums have not been paid. The Plan will not send periodic notices of payments due.

Payment of Amounts Less Than the Full Premium. If timely payment is made to the Plan in amount that is less, but not significantly less than the amount due (if it is no greater than the lesser of $50.00 or 10% of the amount due), the Plan Administrator will notify you of the amount of the deficiency. You will then have a period of 30 days from the date of notice is provided in which to make up the deficient payment. If timely payment is made to the Plan in an amount that is significantly less than the amount due, the Plan Administrator will not provide notice of the amount of any deficiency. In this case, if you do not make up the deficient premium by the original due date of the applicable coverage period, your continuation coverage will terminate as stated under the section below entitled, **Continuation Coverage may be Cut Short.**

Your Responsibility to Notify the Plan

What events must I tell the Plan about?

Under the law, the Participant or a family member has the responsibility to inform the Administrative Manager of a divorce, legal separation, or a Child losing Child status under the Plan, within 60 days of the date of the event. In addition, the Participant or a family member must inform the Administrative Manager of a determination by the Social Security Administration that the Participant or covered family member was disabled during the 60-day period after the Member's termination of employment or reduction of hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. (See **Special Rules for Disability,** below). If, during continuation coverage, the Social Security Administration determines that the Member, or family member is no longer disabled, the individual must inform Administrative Manager of this redetermination within 30 days of the date it is made.

Coverage Choices

What kind of coverage can I obtain?

If you choose continuation coverage, the Plan is required to allow you to purchase coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Participants or family members. This means that if the coverage for similarly situated Participants or family members is modified, your coverage will be modified. ("Similarly situated" refers to current Participants or their Spouses and/or Children who have not had a qualifying event.)

You also will have the right to choose only the "basic" health coverage (Basic Benefits, Miscellaneous Benefits, and Prescription Medicine Benefits), or the "full coverage" option (Basic Benefits, Miscellaneous Benefits, Prescription Medicine Benefits, and Dental). You cannot pick and choose among the health coverage components.

When Coverage Ends

How long will coverage last?

You can maintain continuation coverage for 18 months (if you lost group health coverage because of a termination of employment or reduction in hours) or 36 months (if you lost group health coverage because of any other qualifying event).

If another qualifying event occurs while you are in an 18-month period of continuation coverage, it may be that your continuation coverage will be extended to a total of 36 months. In no event will such coverage extend beyond 36 months from the date of the initial qualifying event. You should notify the Administrative Manager if a second qualifying event occurs during your continuation coverage period within the later of 60 days of the date of the second qualifying event or 60 days of the date the qualifying beneficiary would lose coverage under the Plan as a result of the qualifying event.

Continuation coverage may be cut short. The law provides that a covered individual's continuation coverage may be cut short prior to the expiration date of the 18-, 29-, or 36-month period for any of the following five reasons:

- This Plan no longer provides group health coverage to any Participants.
- The premium for continuation coverage is not paid in full in a timely manner (within the applicable grace period).
- Any time after the latest date that COBRA coverage may be elected under this Plan, the individual becomes covered under another group health plan (whether or not as an employee) that does not contain any exclusion or limitation with respect to any pre-existing condition of the individual (other than an exclusion or limitation that, after July 1, 1997, does not apply to, or is satisfied by, the individual under the provisions of the Health Insurance Portability and Accountability Act of 1996 or that does not apply due to PPACA effective in 2014).
- The individual becomes enrolled in Medicare (under Part A, Part B, or both, or Part D) after electing continuation coverage under this Plan.
- Coverage has been extended for up to 29 months due to disability (see **Special Rules for Disability**) and there has been a final determination that the individual is no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant, Spouse or Child not receiving continuation coverage (such as fraud).

If continuation coverage is terminated for any of the above reasons, the Plan Administrator will provide notice of such early termination of coverage, including the reasons for such termination, the date of the termination and any rights a qualified beneficiary may have to elect any alternative coverage.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay the premium for your continuation coverage.

Special rules apply if you or covered family members are disabled during continuation coverage. Please read the following subsections regarding these situations.

When my continuation coverage ends, can it be reinstated?

Once your continuation coverage terminates for any reason, it cannot be reinstated.

What happens if I don't choose continuation coverage?

If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end.

However, if you decline enrollment in continuation coverage for yourself, your Spouse or your Children because of other health insurance coverage, you may in the future be able to enroll yourself, your Spouse and your Children in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Spouse or Child as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your Spouse and your Children, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Special Rules for Disability

What special rules apply if a covered person becomes disabled?

Special rules for disability. If you or a covered family member are disabled at any time during the first 60 days of continuation coverage, the continuation coverage period is 29 months for all family members, even those who are not disabled. The Social Security Administration must determine the disability that extends the continuation coverage period. The Participant or family member must inform the Administrative Manager within 60 days of the date of disability determination and before the end of the original 18-month continuation coverage period. If, during continuation coverage, the Social Security Administration determines that a Participant or family member is no longer disabled, the individual must inform the Administrative Manager of this redetermination within 30 days of the date it is made. In this case, coverage will not extend beyond the initial 18 month period, and if it has already continued beyond that period, coverage will end on the later of the first day of the month that is more than 30 days after the date of a final determination by the Social Security Administration that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's being entitled to the disability extension is no longer disabled. If a Participant or family member is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction of hours.

Premium for period of disability extension coverage. If you become entitled to an extension in COBRA continuation coverage beyond the original 18 month period due to a disability as described above, the premium for continued coverage will increase to 150% of the cost of coverage, subject to any annual adjustments of costs imposed by the Trustees on COBRA rates, for the 19th month through the 29th month of COBRA continuation coverage. If a second qualifying event occurs as described above, this increased premium will remain in effect up to 36 months from the date of the original qualifying event. However, if a second qualifying event occurs during the first 18 months of coverage, the premium will remain at the same level throughout the entire 36 months of COBRA continuation coverage, without regard to a beneficiary's disability, subject to any annual adjustments of COBRA costs.

SECTION 21

FILING CLAIMS AND APPEALS

This section explains the rules for filing claims and appealing a benefit denial.

Authorized Representatives

Any reference in these procedures to "you" or the "Member" is also a reference to your or the Member's authorized representative making a claim on your behalf or the Member's behalf. The Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf or the Member's behalf.

Insured Benefits vs. Fund Benefits

Are the benefits under this Plan insured, or are they paid directly from the Fund?

Some of the benefits are insured, which means that we pay premiums to an insurance company, which then takes full responsibility for paying the full amount of the claims. The insured benefits are:

- Life Insurance Benefit.
- Accidental Death and Dismemberment Benefit.
- Magellan HRSC, Inc. Employee Assistance Program.

Other benefits are paid directly by the Fund from the accumulated employer and self-pay contributions and any investment earnings on those contributions. The benefits subject to this funding method are:

- Basic Benefits.
- Miscellaneous Benefits.
- Prescription Medicine Benefits.
- Individual HRA (paid from the Individual HRA Plan and Trust).
- Loss of Time Benefits.
- Delta Dental.

The Fund may also purchase insurance (called "stop-loss" insurance) to protect the Fund itself from Basic Benefit claims in excess of certain limits. This insurance is not payable to Members; it is paid to the Fund itself.

Are claims handled differently for benefits that are insured and benefits that are paid directly by the Fund?

Yes. Claims for insured benefits are forwarded to the insurance company that insures the benefit and are subject to the appeals and review procedures of the insurance company. The Trustees have no power over appeals for benefits relating to insured benefits.

Miscellaneous Benefits, Prescription Medicine Benefits and Individual HRA claims are initially processed through the use of your Benefit Advisor Card (in conjunction with the BCBSM Card for Prescription Benefits). For claims incurred with service providers that do not accept VISA and other claims that are not paid through the Benefit Advisor Card, the Administrative Manager processes initial claims for all of the uninsured benefits other than Basic Benefits and Delta Dental. Appeals relating to these claims are handled by the Trustees.

Other than amounts paid by use of the Benefit Advisor Card, the Administrative Manager handles claims for uninsured benefits other than Basic Benefits and Delta Dental directly, subject to appeals to the Trustees. Blue Cross Blue Shield handles claims for Basic Benefits, subject to appeals to the Trustees. Delta Dental provides its own claims and appeal procedure, which is described in Section 23.

If you have a claim for an insured benefit, it should be filed directly with the insurance company. The Administrative Manager will provide claim forms for the MetLife Insurance and Accidental Death and Dismemberment Benefits upon request. Magellan HRSC, Inc. provides the Employee Assistance Plan Benefits directly using their network of providers, so claim forms should not be needed unless you exceed their maximum number of visits, in which case their services may be covered under the Miscellaneous Benefits or Basic Benefits.

If you have a claim for an uninsured benefit other than Basic Benefits or Dental and it was not eligible for payment through the use of your Benefit Advisor Card, it should be filed directly with the Administrative Manager at the address at the end of this SPD. The Administrative Manager makes an initial claims decision on these benefits, subject to appeal to the Board of Trustees. If you obtain services from a service provider that does not accept VISA, your claim is subject to these claims and appeals procedures. You must retain receipts for all services (even those automatically covered with the Benefit Advisor Card) because the Fund Office may need to request receipts to verify expenses are covered. If you cannot substantiate any payments (either through use of the Benefit Advisor Card or otherwise) with receipts, your claim will be denied and you will be required to return any related Benefit Advisor Card payments made by the Plan to the Plan.

If you have a claim for Basic Benefits, it should be filed with Blue Cross Blue Shield. Any appeal of a claims decision made by Blue Cross Blue Shield should be filed with the Administrative Manager at the address at the end of this SPD, for review by the Board of Trustees.

Claims Processor

Who processes initial claims for benefits?

The Plan Administrator has delegated the responsibility for making an initial claims decision to the following:

- The Administrative Manager for Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA Benefits and Loss of Time Benefits;
- BCBSM for Basic Benefits;
- Delta Dental for Dental Benefits; and
- For any insured benefit, the applicable insurance company.

The term "Claims Processor" as used in this section of the Plan refers to whichever of the above is making the initial claims decision.

Basic Benefits Services

If I go to a participating provider for a service covered by the Blue Cross Blue Shield Basic Benefits, do I have to file a claim with Blue Cross Blue Shield for these Basic Benefits services?

No. If you go to a participating provider, you will not have to file claims for Basic Benefits services (those administered by Blue Cross Blue Shield) because claims are submitted directly by the provider to Blue Cross Blue Shield for you and are paid by Blue Cross Blue Shield.

However, if you receive Basic Benefits services from Nonparticipating providers, or you receive care out of the state or out of the country, you may be required to pay the bills and file your own claims with Blue Cross Blue Shield for reimbursement.

How to Submit a Claim

How do I submit a claim for Basic Benefits?

You get a claim form from Blue Cross Blue Shield. The Administrative Manager may be able to assist you with getting claim forms in some cases. You should submit claims as soon as you receive covered services. Generally, if you submit claims beyond the applicable time limit, they will be denied. The time limit is 15 months after the date of service for Basic Benefits claims and 24 months after the date of service for hearing care services claims.

Procedure

What is the procedure for submitting a claim for Basic Benefits?

- Obtain itemized statements from the provider that include the following information:

  - Name of the Patient and the Subscriber's name.
  - Contract number (from your ID card).
  - Name and address of the health care provider.
  - Provider's federal tax ID number.
  - Description of services.
  - Diagnosis (nature of illness or injury).
  - Date of each service.
  - Dates of admission and discharge (if admitted to a hospital).

  NOTE: If you receive medical services out of the state or out of the country, you will need to pay the bill and get an itemized receipt. Try to have all receipts written in English and in U.S. currency.

  You may include cash register receipts, canceled checks or money order stubs with your itemized claim, but they do not substitute for an itemized receipt.

- Complete the appropriate claim form:

  - **Participant Application for Payment** form for Basic Benefits services; or
  - The **Blue Cross Blue Shield Hearing Out-of-State Claim** form for hearing care services.

  NOTE: Hearing care services claims for in-state care should never be necessary because **in-state** care must be provided by participating providers who will submit claims on your behalf

- Complete a separate claim form for each covered person. Multiple services for the same Patient may be attached to one claim form.

- Attach all itemized receipts and statements to the claim form. Make sure the Participant's name and contract number are on all receipts and attachments.

- Review all claim forms to be sure they are accurate and complete. Incomplete forms will cause your payment to be delayed. Be sure to sign and date each claim. Always keep a copy of your claims and receipts because Blue Cross Blue Shield cannot return them to you.

- Mail all claim forms to the address shown on the form. If you do not have a claim form, send the itemized receipt to:

Blue Cross Blue Shield
600 Lafayette East
Detroit, MI 48226
Attn: Department # 0734

How Payment Is Made

How is payment of my claim made?

When you send in your own claims to Blue Cross Blue Shield, you will receive the approved payment directly from Blue Cross Blue Shield. If you have not already paid the provider, it is your responsibility to do so, including the amount that may not be covered by your reimbursement check.

NOTE: When you are reimbursed for a service received out of the country, your coverage will pay the Approved Amount, at the rate of exchange in effect at the time you received care.

What To Do if a Claim is Denied by Blue Cross Blue Shield

What if my claim for Basic Benefits services is denied?

If your claim for payment is denied in whole or in part your Explanation of Benefits (EOB) will indicate the reason for the nonpayment.

You may make an appeal to the Board of Trustees under the appeal procedure that follows.

If I am required to pay a Basic Benefits co-payment or deductible, can I use the Benefit Advisor Card?

You generally cannot use Prescription Medicine Benefits or Miscellaneous Benefits to pay Co-pays or Deductibles (other than Delta Dental co-pays, which can be paid from the Miscellaneous Benefits account), but if you have money in your Individual HRA account, you can use that to pay a Basic Benefits Co-pay or Deductible expense incurred (i.e. services rendered) through the use of the Benefit Advisor Card. Use the card the same way you would use a VISA. Note that if you use your Benefit Advisor Card in a doctor's office or hospital for something that could be covered by Prescription Medicine or Miscellaneous benefits (such as filling a prescription), it will automatically use your Individual HRA account money to pay the bill instead of any Miscellaneous or Prescription Medicine funds you might have available.

Internal Claim Procedure for Uninsured Benefits: Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA and Loss of Time Benefits

How do I make a claim if the service is provided by the Fund directly, and not as an insured benefit or a Basic Benefit administered by Blue Cross Blue Shield or Delta Dental benefit?

Claims for Miscellaneous Benefits, Prescription Medicine Benefits and Individual HRA benefits are processed through the use of your Benefit Advisor Card (in conjunction with your BCBSM Card for Prescription Medicine Benefits). For services incurred with service providers that do not accept VISA, you may make claims for Miscellaneous Benefits and eligible Prescription Medicine Benefits by sending your provider's statement or itemized receipt from your provider or pharmacy to the Administrative Manager, who makes the initial claims decisions on these claims. No form is required.

Please note that if the expense for which you are requesting reimbursement is a medical or dental expense, you must provide the Administrative Manager with an Explanation of Benefits ("EOB") substantiating the expense. To be eligible for payment, all claims for reimbursements under these reimbursement funds must be submitted to the Fund by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued. The statement or receipt must show the date of service, the covered person receiving the services and a description of the service

performed. For Prescription Medicine Benefits the receipt must show the date of purchase and identify the prescription medication received. Benefit payments are subject to the Administrative Manager's acceptance of the proof provided. Claims received by the tenth of the month, if approved, will be paid by the last day of the month.

You may make a claim for Loss of Time Benefits by requesting the appropriate form and filing it with the Administrative Manager and providing proof of your inability to work because of a non-occupational Accidental Injury or sickness and proof that you are under the care of a physician. The form also may be downloaded from the Fund web site, http://www.ua190benefits.org. The Administrative Manager makes initial claims decisions for Loss of Time Benefits. Benefit payments are subject to the Administrative Manager's acceptance of the proof provided.

You may make a claim for Individual HRA benefits that are not covered by the Benefit Advisor card by getting an Individual HRA Reimbursement Request Form from the Administrative Manager and sending the form with your itemized receipt from your provider or pharmacy to the Administrative Manager. The form also may be downloaded from the Fund web site, http://www.ua190benefits.org. The Administrative Manager makes initial claims decisions for these claims. Benefit payments are subject to the Administrative Manager's acceptance of the proof provided.

Remember to save your receipts for all services (even those automatically covered with the Benefit Advisor Card) because the Fund Office may need to request receipts to verify expenses are covered. If you cannot substantiate any payments (either through use of the Benefit Advisor Card or otherwise) with receipts, your claim will be denied and you will be required to return any related Benefit Advisor Card payments made by the Plan to the Plan.

How do I file a claim for continuing injury or sickness?

If you have a continuing injury or sickness that requires regular courses of repeated treatment or qualifies for Loss of Time Benefits, and you notify the Plan within the time frames described in this section, you may be able to file one claim and have the Plan continue to pay benefits on that basis. Written notice of injury or sickness upon which a claim may be based must be given to the Administrative Manager within 90 days of the date of the commencement of the first loss for which benefits arising out of each such injury or sickness may be claimed. The Administrative Manager may, in its discretion, require claims to be filed for each treatment event.

If benefits stop because you have not provided adequate proof of loss, written proof of loss must be furnished to the Administrative Manager in case of continuing loss within 90 days after the end of the period for which the Fund provides for payment of benefits, and in case of claim for any other loss, within 90 days after the date of the loss.

In any case, written proof of loss must be furnished to the Administrative Manager by the later of the following dates: 1) February 15 of the year after the calendar year in which the expense was incurred (i.e., when the services were rendered or items were purchased), or 2) 60 days after the Explanation of Benefits or other notification to the Member of the Member's share of the medical expense is issued.

Failure to furnish notice or proof within the time provided for above will not invalidate or reduce any claim if it was not reasonably possible to furnish notice or proof within the time period provided above, and notice or proof was furnished as soon as was reasonably possible.

When the Administrative Manager receives the required notice or proof, the Administrative Manager will provide the claimant with the forms usually furnished for filing proof of loss. If the forms are not furnished within 15 days after the Administrative Manager receives notice or proof, the claimant is deemed to have complied with the notice requirements as to proof of loss upon submitting, within the time limit for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

All amounts owed for continuing loss will be paid each two weeks during any period for which the Fund is providing benefits, and any balance remaining unpaid upon termination of such period will be paid immediately upon receipt of due proof.

If you request an extension of treatment at least 24 hours before the end of the originally approved length of time or number of treatments, you will be notified of the Plan's decision 24 hours after the Plan receives the claim. Any request for such an extension involving urgent care will be decided as soon as possible, taking into account the medical circumstances.

What other rules apply to claims?

Benefits for loss of life, if any, will be paid to the covered person's Beneficiary. All other benefits provided under the Plan are payable to the covered person.

The Fund will have the right and opportunity to have the person whose injury or sickness is the basis of the claim examined by a licensed physician when and so often as it may reasonably require while any claim is pending.

No lawsuit may be brought to recover benefits before completion of the Appeals Procedure and in no case before the expiration of 60 days after proof of loss has been filed in accordance with the notice requirements, nor may a lawsuit be brought after two years from the time within which proof of loss is required.

You have the sole right to select your own physician, surgeon and hospital, and a physician-patient relationship shall be maintained.

The Plan is not a replacement for and does not affect any requirements for coverage by Workers' Compensation insurance.

Timing of Initial Decision and Calculating Time Periods

How long does the Claims Processor have to decide whether a claim should be paid?

The period of time within which a benefit determination is required to be made will begin at the time a claim is filed in accordance with the procedures set forth below, without regard to whether all of the information necessary to make a benefit determination accompanies the filing. If a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

General Claims

The following claims procedure will apply to claims other than insured benefits, claims made for health benefits, and claims for Loss of Time benefits under the Plan.

Under normal circumstances, within 90 days after the Administrative Manager receives your claim for benefits, the Claims Processor will notify you, in writing, about its decision on your claim. If special circumstances require longer than 90 days to process the claim, the Claims Processor may take up to another 90 days to send you a notice of its decision. In that case, the Claims Processor will send you a written notice of the need for an extension before the end of the first 90-day period. The notice will include the reason for the extension and the date by which a final decision is expected to be made.

Loss of Time Claims

The following claims procedure will apply specifically to claims made for Loss of Time benefits.

If a claim for Loss of Time benefits is denied in whole or in part, you or your beneficiary will receive written notification within a reasonable period of time, but no later than 45 days after the Claims Processor's receipt of the claim. The Claims Processor may extend this period for up to 30 additional days provided the Claims Processor determines that the extension is necessary due to matters beyond the Claims Processor's control and the Member is notified, before the end of the initial 45-day period, of the circumstances requiring the extension and of the date by which the Claims Processor expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Processor determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Processor expects to render a decision. Any extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information.

Medical Claims

The following claims procedure will apply specifically to claims made for group health plan benefits (Basic Benefits, Dental Benefits, Miscellaneous Benefits, Prescription Medicine Benefits and Individual HRA Benefits).

Urgent Claims That Require Immediate Action

"Urgent Care Claims" are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible taking into account the medical exigencies, but not later than 72-hours after the Claims Processor receives all necessary information.

- Notice of denial may be oral with a written confirmation to follow within 3 days.

If you filed an Urgent Care Claim improperly, the Claims Processor will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Processor will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

In determining whether a claim is urgent, the Claims Processor will defer to the determination of a Member's attending provider.

You will be notified of a determination no later than 48 hours after:

- The Claim Processor's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Special Rules for Concurrent Decisions

1. Member's request to extend previously approved course of treatment.

Urgent care. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and a request to extend the treatment is an Urgent Care Claim, the request will be decided by the Claims Processor within 24 hours of the receipt of the request, provided the request is made at least 24 hours prior to the end of the approved treatment. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described below.

Non-urgent care. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and a request to extend treatment is not an Urgent Care Claim, the request will be considered a new claim and decided according to the post-service or pre-service timeframes described below, whichever applies.

2. Plan reduces or terminates a previously approved course of treatment.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan reduces or terminates the course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the reduction or termination will be considered a Claim Denial (as defined below) and you will be notified of the reduction or termination (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Pre-Service Claims

"Pre-Service Claims" are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Claim Processor within a reasonable period of time, but not later than 15 days, following the receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Processor will notify you of the improper filing and how to correct it within 5 days of receipt of the Pre-Service Claim.

The Claims Processor will notify you of its determination within 15 days after the claim is received, unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Claims Processor expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Claims Processor or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, the Claims Processor will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension will not exceed 15 days from the end of the initial 15 day period.

When will I be notified?

- Generally, only long term acute care facility services, certain noncontracted hospital services, and certain prescription medicines require approval before you receive the benefits.

- There is no requirement that you seek advance approval for Miscellaneous Benefits, Prescription Medicine Benefits, or Individual HRA benefits under the Plan, <u>except</u> when the expense is for a prescription medicine on BCBSM's pre-authorization list. Most treatment that would be needed on an urgent basis will fit the criteria for Miscellaneous Benefits, so you should not seek advance approval of Miscellaneous Benefit coverage if treatment is needed in an emergency.

- However, if you ever are uncertain about whether an expense you will incur is eligible for reimbursement as a Miscellaneous Benefit, you can request an advance determination. This would make sense only if the treatment in question was optional and not immediately required. We have tried to provide you with lots of examples in this SPD of the types of expenses that are or are not eligible, but the final decision as to whether something is eligible for Miscellaneous Benefit coverage is up to the Claims Processor or, if appealed, the Board of Trustees.

Post-Service Claims

"Post-Service Claims" are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice of the claim decision (whether or not adverse) from the Claims Processor within a reasonable period of time, but not later than 30 days, following the receipt of the claim, as long as all needed information was provided with the claim.

The Claims Processor will notify you of its determination within 30 days after the claim is received, unless the Claims Processor determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Claims Processor expects to render a decision shall be furnished to you prior to the end of the initial 30-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Claims Processor or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, the Claims Processor will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension will not exceed 15 days from the end of the initial 30-day period.

Appeals Procedure

Can I appeal a denial?

Yes. If your claim for coverage for Basic Benefits, Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA Benefits or Loss of Time Benefits is denied by the Claims Processor (either the Administrative Manager, BCBSM or Delta Dental), you have the right to a full and fair review by the Board of Trustees.

General Procedures

The following appeals procedure will apply to claims made for benefits under the Internal Claims Procedures.

- The Plan must allow you to review the claim file and to present written evidence as part of the internal claims and appeals process.

- Any decision regarding hiring, compensation, termination, promotion or similar matters with respect to an individual such as a claims adjudicator or a medical expert must not be based upon the likelihood that the individual will support a denial of benefits.

- The Board of Trustees will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the group health plan (or at the direction of the Board of Trustees) in connection with your claim; this evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Claim Denial is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give you a reasonable opportunity to respond prior to that date.

- Before the Board of Trustees can issue a Final Internal Claim Denial based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Claim Denial is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give you a reasonable opportunity to respond prior to that date.

"Claim Denial" Defined

For purposes of these review procedures, a "Claim Denial" means:

- A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a benefit under the Plan;
- This includes denials based on a determination that you are ineligible to participate in the Plan;
- For medical benefits, it also includes a denial from the application of any utilization review (a review of your request for a benefit, confirmation that the benefit is covered and confirmation that the treatment would be or was effective);
- For medical benefits, it also means a failure to cover an item or service that would otherwise be provided and is not provided because it is found experimental or investigational or not medically necessary or appropriate;
- It also means a rescission of coverage (a cancellation or discontinuance of coverage that is retroactive (applies back to a date in the past)).
- It does not mean a cancellation of coverage that is prospective (applies in the future); and
- It does not mean a cancellation or discontinuance of coverage that is retroactive if it is due to a failure to timely pay required premiums or contributions for coverage.

Notice of Initial Claim Denial

If your claim is wholly or partially denied, or you experience a rescission of coverage, the Claims Processor will furnish you with a written notice of the Claim Denial. The written notice will set forth the following information, in a manner calculated to be understood by you:

(a) The specific reason or reasons for the Claim Denial;

(b) Specific reference to those Plan provisions on which the Claim Denial is based;

(c) A description of any additional information or material necessary to perfect the claim and an explanation of why such material or information is necessary;

(d) Appropriate information as to the steps to be taken if you wish to submit the claim for review;

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Claim Denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

(f) If the Claim Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(g) In the case of a Claim Denial by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(h) A statement indicating that you will be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

(i) In the case of a Claim Denial:

- The Plan must ensure that any notice of Claim Denial includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable).

- You will be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice will contain a statement to such effect.

- The Plan must ensure that the reason or reasons for the Claim Denial includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.

- The Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

- Notices will be provided in a culturally and linguistically appropriate manner.

How to Appeal a Claim Denial

All Claim Denials are subject to at least one opportunity for a full and fair review. This review is called the "internal appeal."

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. The Board of Trustees reviews claims denied by the Administrative Manager and Blue Cross Blue Shield of Michigan. Insured claims and Delta Dental claims are not subject to review by the Board of Trustees and are subject to the claims and appeals process of the insurer for insured benefits and Delta Dental for Dental Benefits.

In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review of your claims will take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination.

If you ask us to, the Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Claim Denial, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.

- The date(s) of health care service(s).

- The provider's name.

- The reason you believe the claim should be paid.

- Any documentation or other written information to support your request for claim payment.

Claims Unrelated to Denial of Payment for Specific Benefits

You may appeal any denial of a claim within 60 days of a denial by submitting a written request for review to the Plan Administrator.

What Happens when You Appeal Loss of Time and Group Health Plan Claim Denials

For purposes of this appeal procedure, "group health plan" means the following benefits:

- Basic Benefits;
- Miscellaneous Benefits;
- Prescription Medicine Benefits;
- Individual HRA Benefits;
- Dental Benefits; and
- Certain benefits under the Employee Assistance Program.

The following appeals procedure will apply to claims made for benefits under a group health plan or for loss of time benefits.

You may appeal any Claim Denial within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator (the Board of Trustees).

The review of your appeal will involve a "fresh look" by the Board of Trustees, and the Board of Trustees will not give any extra weight to the initial claim decision. If any Trustees were involved in the initial Claim Denial, they will not participate in the review of your appeal. If all Trustees were involved in your initial Claim Denial, you will be referred immediately to an independent review organization that handles the external appeal procedure. See "External Review Process" later in this section.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Claim Denial that is the subject of the appeal, nor the subordinate of any such individual.

If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Board of Trustees may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

In the case of a claim under a group health plan involving urgent care, you are entitled to an expedited review process pursuant to which—

- You may submit a request for an expedited appeal of a Claim Denial orally or in writing; and
- All necessary information, including the Plan's benefit determination on review, shall be transmitted from the Plan to you by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended as permitted below due to your failure to submit information necessary to decide an appeal, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

Timing of Internal Appeal Decision

Except as provided below for Pre-Service and Urgent Care claim appeals, the Board of Trustees will make a benefit determination no later than the date of the meeting of the Board of Trustees that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In that case, a benefit determination may be made by no later than the date of the second meeting of the Board of Trustees following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees will provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made,

prior to the commencement of the extension. The Board of Trustees will notify you of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Notice of Appeals Determinations

Pre-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), you will be notified by the Plan Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for appeal of a denied claim.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals That Require Immediate Action" below.

Please note that the Board of Trustees' decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is right for you is between you and your doctor.

Urgent Care Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Board of Trustees as soon as possible. The Board of Trustees will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

- If the Claim Denial involves a medical condition for which the time frame for completion of an Internal Appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may file a request with the Board of Trustees for an "expedited external review."

The Board of Trustees has the exclusive right to interpret and administer the provisions of the Plan. The Board of Trustees' decisions are conclusive and binding. The Board of Trustees has final claims adjudication authority under the Plan.

Manner of Notification of Appeal Decision

The Board of Trustees will provide a Member with written or electronic notification of a Plan's benefit appeal decision. If the appeal is denied (an "Internal Appeal Denial"), the notification will set forth, in a manner calculated to be understood by you:

(a) The specific reason or reasons for the Internal Appeal Denial;

(b) Reference to the specific Plan provisions on which the Internal Appeal Denial is based;

(c) A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Member's right to obtain the information about such procedures;

(e) A statement of the Member's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended;

(f) In the case of a group health plan or a plan providing disability benefits—

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Internal Appeal Denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the final Claim Denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

- If the Internal Appeal Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(g) A statement indicating that you will be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

(h) In addition:

- The Plan must ensure that any notice of Internal Appeal Denial includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable).

- You will be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice will contain a statement to that effect.

- The Plan must ensure that the reason or reasons for the Internal Appeal Denial includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim.

- The Plan must provide a description of External Review processes, including information regarding how to initiate an appeal.

- Notices will be provided in a culturally and linguistically appropriate manner.

Voluntary Extensions

As described above, the Board of Trustees must decide your claim and/or appeal within certain time frames, and the Board of Trustees may extend those time frames in its discretion in certain circumstances. In addition, the Board of Trustees may request that you voluntarily agree to allow the Board of Trustees additional time extensions. You may allow or deny these additional "voluntary" extensions in your discretion.

External Review Procedures

With respect to Basic Benefits, Miscellaneous Benefits, Prescription Medicine Benefits, Individual HRA Benefits and Dental Benefits:

- You may be entitled to request an external review of an internal appeal claim denial by the Plan (an "External Review"); and

- If your situation is urgent, you may be entitled to an Expedited External Review of a claim denial by the Plan (an "Expedited External Review").

External Review Process

This External Review Process follows interim guidance from the federal agencies that are responsible for Health Care Reform, and apply effective January 1, 2014 until replaced by future guidance.

External Review is not available for all Internal Appeal Denials. For example, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a plan is not eligible for External Review. In addition, the External Review Process is suspended until further notice except for claims relating to rescissions and/or medical judgment. The Plan Administrator further reserves the right to exclude from External Review additional types of claim denial as may be permitted under Health Care Reform and any related guidance issued from the federal agencies that are responsible for implementation of Health Care Reform.

External Review

"External Review" is External Review that is not considered expedited (as described below and referred to as "Expedited Internal Review").

The Plan Administrator (the Board of Trustees) will allow you to file a request for an External Review with the Plan Administrator if the request is filed within four months after the date of receipt of a notice of a claim denial. If there is no corresponding date four months after the date of receipt of that notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days following the date of receipt of the External Review request, the Administrative Manager will complete a preliminary review of the request to determine whether you meet all of the following requirements for External Review:

(a) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(b) The Internal Appeal Denial does not relate to the your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

(c) The internal Appeal Denial relates to rescission of coverage or medical judgment or "medical necessity;"

(d) You have exhausted the Plan's internal appeals process unless you are not required to exhaust the internal appeals process under applicable regulations; and

(e) You have provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Administrative Manager will issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Plan will allow a Participant to perfect the request for External Review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The Administrative Manager will refer requests that are eligible for External Review to Blue Cross Blue Shield of Michigan, which will assign an independent review organization ("IRO") that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, Blue Cross Blue Shield will take action against bias and to ensure independence. Accordingly, Blue Cross Blue Shield of Michigan will contract with IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other

independent, unbiased methods for selection of IROs, such as random selection). Blue Cross Blue Shield of Michigan will contract with at least three IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO will provide the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(c) Within five business days after the date of assignment of the IRO, the IRO Referrer will provide to the assigned IRO the documents and any information considered in denying the Claim or Internal Appeal Denial. Failure by the IRO Referrer to timely provide the documents and information must not delay the conduct of the External Review. If the IRO Referrer fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Claim Denial. Within one business day after making the decision, the IRO must notify you and the IRO Referrer.

(d) Upon receipt of any information submitted by you, the assigned IRO will within one business day forward the information to the Administrative Manager. Upon receipt of any such information, the Administrative Manager will forward it to the Board of Trustees to reconsider the Claim Denial that is the subject of the External Review. Reconsideration by the Board of Trustees must not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Board of Trustees decides, upon completion of its reconsideration, to reverse the Claim Denial and provide coverage or payment. Within one business day after making such a decision, the Board of Trustees must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Board of Trustees.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim “de novo” (that is, take a “fresh look” at the claim) and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you or your treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan or the Plan Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO must provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of final External Review decision to you and the Plan.

(g) The assigned IRO's decision notice will contain:

- A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

- The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you; and

- A statement that judicial review may be available to you

(h) After a final External Review decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final External Review decision reversing the Claim Denial, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim.

Expedited External Review

The Plan must allow you to make a request for an Expedited External Review with the Plan at the time you receive:

(a) An Internal Appeal Denial that involves a medical condition of yours for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(b) An Internal Appeal Denial, if you have a medical condition where the time frame for completion of a Standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Internal Appeal Denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for Expedited External Review, the IRO Referrer will determine whether the request meets the reviewability requirements set forth Above for Standard External Review. The IRO Referrer will immediately send a notice that meets the requirements set forth above for Standard External Review to you of its eligibility determination.

Upon a determination that a request is eligible for External Review following the preliminary review, the IRO Referrer will assign an IRO pursuant to the requirements set forth above for Standard External Review. The IRO Referrer will provide or transmit all necessary documents and information considered in making the Claim Denial to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of final External Review decision. The Plan's contract with the assigned IRO must require the IRO to provide notice of the final External Review decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the IRO's notice of decision is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Plan.

Questions About Your Claims and Appeal Rights

For questions about your rights, these claims procedures, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

SECTION 22

COORDINATION OF BENEFITS AND SUBROGATION

This section includes helpful information about these important topics:

- Coordination of Benefits.
- Subrogation.

Coordination of Benefits (COB)

What does Coordination of Benefits mean?

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, but without duplicate payments. Your Plan requires that your Benefit payments be coordinated with benefit payments from another group plan under which you are covered for services that may be payable under both plans so that payment responsibilities will be fair.

COB makes sure that the level of payment when added to the benefits payable under another group plan, will cover up to 100% of the eligible expenses as determined between the carriers, at least to the extent the two plans together will provide 100% of coverage. COB also makes sure that the combined payments of all coverage will not exceed the actual cost approved for your care.

How COB Works

How does COB work?

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

- The carrier that pays first is your **primary plan**. This plan must provide you with the maximum benefits available to you under the plan.
- The carrier that pays second is your **secondary plan**. This plan provides payments toward the balance of the cost of covered services-up to the total allowable amount determined by the carriers.

Guidelines to Determine Primary and Secondary Plans

- If a group health plan does not have a Coordination of Benefits provision, that plan is primary.
- The plan that covers the Patient as the employee is primary and pays before a plan that covers the Patient as a Spouse or Child.
- If a Child is covered under both the mother's and father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.
- For Children of divorced or separated parents, benefits are determined in the following order unless a court order places financial responsibility on one parent: First, the plan of the custodial parent and second, the plan of noncustodial parent.
- If the primary plan cannot be determined by using the guidelines above, then the plan that has been covering the Child the longest is primary.

- The above guidelines apply except for certain situations in which an employee has retired or been laid off. Then special rules apply. Call the Administrative Manager if this applies to you.

Filing Blue Cross Blue Shield COB Claims

Always submit claims to your primary carrier first. When you submit claims to Blue Cross Blue Shield for reimbursement of the balance, please follow these steps:

- Obtain an Explanation of Benefits (EOB) from the primary carrier.
- Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service, and submit this.
- If you made any payments for the service, provide a copy of the receipt you received from the provider.
- 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 identification number (PIN). If the provider is located outside of Michigan, include the provider's tax ID number.

Send these items to:

Blue Cross Blue Shield
600 Lafayette East
Detroit, Michigan 48226
Attention: COB Department # B571

Please make copies of all forms and receipts for your own files before you submit them, because Blue Cross Blue Shield cannot return the originals to you.

Filing Fund COB Claims for Miscellaneous Benefits

What if the claim is for Miscellaneous Benefits?

When a Participant, Spouse or Child is covered under more than one plan for a service that under this Plan is not a Basic Benefit, but instead a Miscellaneous Benefit paid directly by the Fund, a costly duplication of benefits can result. Coordination of Benefits (COB) assures that all medical coverage you have (including, for example, policies for athletic injuries and cancer) will be accessed. After these policies have paid for your medical services according to their limits, the Fund will pay the remaining charges, subject to the limits set forth in this SPD.

Claims should be mailed to the address of the Administrative Manager at the end of this SPD.

Updating COB Information - Your Responsibility

What is my responsibility regarding COB claims?

It is important that you keep your COB records updated. For Blue Cross Blue Shield or the Fund to properly determine whether other plans may be involved in the payment of your medical expenses, it is necessary for the Participant to complete and submit a yearly COB questionnaire. If there are any changes in coverage information for your Spouse or Children, notify Blue Cross Blue Shield or the Administrative Manager's Office immediately. Please help Blue Cross Blue Shield or the Fund serve you better by responding to requests for COB information.

Outdated information can affect payment of your claims as follows:

If the information you provided on your initial COB questionnaire is over one year old and you submit a claim for benefits, your claim will be held up temporarily. The Administrative Manager's Office will send you a letter requesting information about other health care carriers. When you respond, the Administrative Managers Office will update your record. Your claim will then be processed according to the COB rules described above.

Subrogation

What is subrogation?

In certain cases, a third party (another person, insurance company or organization) may be legally obligated to make payment(s) to you relating to an injury or illness for which the Fund would otherwise pay the related costs and expenses. When this happens, the Fund is not required to pay for anything that the third party would otherwise pay for. If the Fund does, anyway, it has all the rights that you would have in any partial or full recovery you eventually get from the third party (up to the amount that the Fund paid).

How does it work?

- The Fund may go ahead and make the payments it would make if there were no third party involved. It may require you to sign a Subrogation Agreement before it does this.

- You must attempt to pursue any claims again the third party, and do whatever is necessary to help the Fund pursue such claims.

- The Fund is entitled to any payment that you receive from the third party, up to the amount it has paid relating to the injury or illness. This is the case:

    - no matter what form the payment come in (ex. through a lawsuit, settlement or any other means),
    - even if you only ever get partial recovery (rather than full recovery) from the third party, and
    - no matter how the recovery is characterized (for example, whether described as relating to medical expenses or not).

- Until the Fund has received full reimbursement out of the payment(s) from the third party, it has a security interest in and/or lien against those payments.

- These provisions do not apply to payments you receive because of your having purchased additional insurance coverage in your own name.

Effect of Medicaid Coverage

What if I am covered by Medicaid?

Benefits under this Plan will be paid without regard to whether the Participant Spouse or Children are covered by Medicaid, and payment of benefits will be made in accordance with any assignment of rights as required by a state Medicaid program and benefits will be paid in accordance with any state law under which the state has acquired the rights to payment with respect to a Participant, Spouse or Child entitled to coverage under the Plan.

SECTION 23

DELTA DENTAL PLAN OF MICHIGAN COVERAGE

You have available dental care coverage administered by Delta Dental. Your plan is called Delta Dental. In addition to this description, a Summary of Dental Plan Benefits shall be provided to you directly by Delta Dental.

Delta Dental pays 50% of the Approved Amount of most basic dental services, including diagnostic and preventive services and emergency palliative treatment, and prosthodontic services, up to a cumulative amount of $800 per covered person per calendar year (this is 50% of $1,600 of Approved Amount). This annual limit does not apply to pediatric dental services (services for Children through the age of 18). However, pediatric dental services are subject to the 50% co-payment requirement. A specification of just what is covered and not covered is set forth below in the subsection entitled **Delta Dental USA Plan Benefits, Exclusions and Limitations**.

Eligibility

Who is eligible for the Delta Dental coverage?

The eligibility rules for Delta Dental coverage are exactly the same as for your other health care coverage, as it is part of the same plan. If you, your Spouse and your Children are eligible for the medical and hospital coverage, you are eligible for Delta Dental coverage.

Contracting Dentists

Must I use a dentist who contracts with Delta Dental?

No, but as with medical coverage, it is certainly easier and more efficient if you do so. Dentists who contract with Delta Dental are referred to as Contracting Dentists. You will find that most dentists in Michigan do contract directly with Delta Dental. See the following paragraphs with regard to how claim processing and reimbursement differs.

Method of Payment

Does Delta Dental pay the dentist directly, or reimburse me?

It depends on whether you use a Contracting Dentist or not. If you use a Contracting Dentist, Delta Dental pays the dentist directly based on the dentist's contract, you receive a statement of the amount paid, and you are obligated for the balance. If you do not use a Contracting Dentist, then your dentist needs to submit your claim to Delta Dental, and Delta Dental will reimburse you the approved amount. (See below.) In this case, you are obligated to pay your dentist the full amount of the dentist's fees, which is usually expected at the time the services are rendered. You need to be sure your dentist submits your claim.

If your dentist is not familiar with Delta Dental, has any questions or needs a claim form, have him or her contact Delta Dental by writing to Delta Dental Plan of Michigan, Inc., P. 0. Box 30416, Lansing, Michigan 48909-7916 or by calling 517-349- 7781 or its toll-free number, 1-800-462-7283.

Claims, adjustment requests and completed information requests should be mailed to Delta Dental at the following address: Delta Dental Plan of Michigan, Inc., P. 0. Box 9085, Farmington Hills, Michigan 48333-9085.

Amount of Coverage

How much of my dentist's fees will Delta Dental pay?

For Contracting Dentists, Delta Dental will pay 50% of the amount established by the Delta Dental contract as the fee for the particular services rendered. For dentists who are not under the Delta Dental contract, Delta Dental pays one-half of the fee Delta Dental determines is usual or customary, which means within the range of usual fees charged by dentists of similar training and experience for the same service within the same specific and limited geographic area; and the fee must also be reasonable considering the special circumstances of the particular case. The fee that Delta Dental determines is usual or customary, toward which it pays 50%, may be less than the fee charged you by a non-contracting dentist.

Coverage Provisions

What dental work is covered and what is not covered?

Please see the pages at the end of this explanation section entitled **Delta Dental Plan Benefits, Exclusions and Limitations** for specification of the procedures that are covered, what procedures are not covered, and what costs are paid by Delta Dental. Delta Dental covers what are referred to as Class 1 and Class 2 Benefits.

Arranging for Dental Work

How do I arrange for dental work that is to be covered by Delta Dental?

Make an appointment with the dentist of your choice and tell your dentist if you are covered under Delta Dental. Claim forms are provided to each dental office in Michigan for your convenience.

You or a member of the dental office staff must fill in the information portion of the claim form with the following:

- The Participant's full name and address.
- The Participant's social security number.
- The name and date of birth of the person receiving the dental care.
- The group name and number.

If your dentist is not located in Michigan or if your dentist cannot provide you with a claim form, you or your dentist can get a claim form from Delta Dental, as described above. Although your dentist is supposed to send the claim form in for you, you need to make sure this is done.

Predetermination

Do I have to get a pre-approval to assure proposed dental work is going to be covered by Delta Dental?

It is highly advisable for you to be pre-approved for dental work if the cost is to exceed $200. Delta Dental has a procedure for quick review of proposed work, and it is the only way you can be assured that coverage will be applicable. This procedure is called Predetermination.

After a routine oral examination, your dentist will list any necessary treatment on your claim form. If the cost of these services is less than the specified Predetermination amount of $200 or is limited to emergency care, Predetermination is not necessary.

Delta Dental strongly recommends that you have your dentist forward your treatment plan (claim form) to Delta Dental for Predetermination before he or she performs any services where the total charges will exceed the specified Predetermination amount. This Predetermination procedure will let you and your dentist know what services may be covered, what Delta Dental may pay under the terms of your Plan and what you may have to pay. Because this Predetermination procedure requires a minimal amount of time, it normally will not interfere with scheduling your appointments. You and your dentist should review your Predetermined claim before your dentist proceeds with treatment.

Disputes, Appeal and Review

What if I wish to question a decision concerning payment?

If your question concerns eligibility, call the Administrative Manager. If your question concerns payment for a particular dental service, proceed through Delta Dental's disputed claims procedure as follows.

Before following Delta Dental's disputed claims procedure, you or your dentist should resubmit the claim as an inquiry to confirm that Delta Dental's determination was correct and that all supporting documentation was submitted. Please note that contractual exclusions and limitations cannot be altered. If the claim is still denied, you can follow this disputed claims procedure.

Your disputed claim for benefits must be written and mailed by certified mail, return receipt requested, to the Dental Director, Delta Dental Plan of Michigan, Inc., P. 0. Box 30416, Lansing, Michigan 48909-7916.

Your written statement must indicate the Participant's full name and address, the Participant's social security number, and specific basis for your claim and any additional materials you wish to present. The Dental Director or designee will promptly review your statement and, if the claim is wholly or partially denied, may furnish you with a notice of the decision within 90 days of receiving the statement. The written notice will set forth:

- The specific reason or reasons for denial.
- The specific reference to the pertinent Plan provisions on which the denial is based.
- If applicable, a description of any further material or information necessary for you to provide and an explanation of why the material or information is necessary.
- A copy of the disputed claims appeal procedure.

If you do not receive notice within the 90-day period, the claim is considered denied and you can proceed to the disputed claims appeal procedure.

What if I am still not satisfied after going through the disputed claim procedure?

If you are still not satisfied, then you may file an appeal of your claim. After following the disputed claims procedure, you or your authorized representative may appeal to the Administrative Committee of Delta Dental (Administrative Committee) by filing a written request for review before the final appeal date set forth in the Dental Director's notice denying the disputed claim, or, if no date is given, within 150 days of submitting the initial written statement under the disputed claims procedure. Your written request must state specifically the reasons for requesting a review and why you believe the Dental Director's decision was incorrect. You or your authorized representative may review the plan and pertinent documents.

If you want a hearing, make your request to the Administrative Committee. The Administrative Committee, in its sole discretion, may, but is not required to, convene a hearing to consider matters raised in the written request. If the hearing is granted, you are entitled, at your own expense, to be represented by legal counsel, to request that a court reporter transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine the witnesses.

If no hearing is held, the Administrative Committee will render its decision not later than 60 days after receiving the written request for review. If a hearing is held, a decision will be rendered as soon as possible, but not later than 120 days after receiving your written request for review. The Administrative Committee's decision will be in writing and will include specific reasons for the decision, with specific references to pertinent Plan provisions on which the decision is based.

External Review Process

If your Administrative Committee appeal is denied, you may have the right to obtain external review of that decision. See "External Review Procedure" in Section 21.

Termination of Coverage

Can my Delta Dental coverage be terminated?

Your coverage, as with all aspects of the Plan, may be terminated if the Trustees eliminate or change the Plan, or if you lose eligibility for the Plan. Your coverage will terminate on the last day of the month in which either of these situations occurs. If the plan terminates, you will become responsible for payment of your dental expenses.

Coordination of Benefits, COBRA

Do Coordination of Benefits, Subrogation and COBRA all apply to the Delta Dental program?

Yes, all of those apply as set forth in the Plan.

What if my Spouse is covered by another dental plan?

Using both plans, you may be entitled to coverage for as much as (but not more than) 100% of the charges for covered dental services. It is important that you inform your dentist of any dual coverage so that the proper claim filing procedures are followed.

Miscellaneous Benefits Applicable

May I use any remaining Miscellaneous Benefits under the Plan to cover either the percentage of my dental bills not paid by Delta Dental or for services not covered by Delta Dental?

Yes, that is what the Miscellaneous Benefits are for. For services provided by a service provider that does not accept VISA, you must submit the balance of the claim to the Administrative Manager for reimbursement. You must also submit the Delta Dental EOB (Explanation of Benefits) with your claim.

Delta Dental Plan Benefits, Exclusions and Limitations

Class 1 Benefits that are covered:

- **Diagnostic and Preventive Services.** Services and procedures to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Such services might include examinations, prophylaxes and topical applications of fluoride.

- **Emergency Palliative Treatment.** Nonspecific treatment employed by dentists on an emergency basis to temporarily relieve pain.

- **Radiographs.** X-rays, as required or in conjunction with the diagnosis of a specific condition.

- **Oral Surgery Services.** Extractions and other surgical dental procedures, including preoperative and postoperative care.

- **Endodontic Services.** Procedures for the treatment of teeth with diseased or damaged nerves (for example, root canals).

- **Periodontic Services.** Procedures for the treatment of diseases of the gums and supporting structures of the teeth.

- **Restorative Services.** Services to rebuild, repair or reform natural tooth structure when necessary due to disease or injury. Restorative services include, but are not limited to, those listed below:

    - Minor restorative services such as amalgam and resin restorations and relines and repairs to prosthetic appliances.
    - Major restorative services such as jackets on anterior teeth and cast restorations when the teeth cannot be restored with another filling material.

Class 2 Benefits that are covered:

Prosthodontic Services. Services and appliances, such as bridges, partial denture and complete dentures that replace missing natural teeth.

Exclusions

No benefits will be provided for the following. You will be responsible for the charges for these services:

- Services for injuries or conditions compensable under Workers' Compensation or Employer's Liability laws; or benefits or services that are available from any federal or state government agency, from any municipality, county or other political subdivision or community agency, or from any foundation or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX Social Security Act, that is, Medicaid.

- Services that are determined by Delta Dental to be rendered to correct congenital malformations, cosmetic surgery or dentistry for cosmetic reasons.

- Services or appliances, including, but not limited to, prosthodontics (including crowns and bridges), started before an individual became eligible under this Plan.

- Prescription drugs, laboratory tests and/or examinations, premedications and/or relative analgesia; charges for hospitalization; general anesthesia and/or intravenous sedation for restorative dentistry; general anesthesia and/or intravenous sedation for surgical procedures, unless it is a medical necessity; preventive control programs, including home care items; and charges for failure to keep a scheduled visit with the dentist.

- Replacement repair, relines or adjustments of occlusal guards.

- Charges for completion of forms. These charges are not to be made by a Contracting Dentist to a person covered by Delta Dental.

- Sealants.

- Orthodontic services or supplies.

- Lost, missing or stolen appliances of any type and replacement or repair of orthodontic appliances.

- Services that are not necessary and/or customary as determined by the standards of generally accepted dental practice, for which no valid dental need can be demonstrated, that are specialized techniques or that are Experimental or Investigative in nature.

- Services that are not within the classes of Dental Benefits defined in the Plan.

- Appliances, surgical procedures and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion or erosion; for correcting congenital or developmental malformations; for aesthetic purposes; or for implantology techniques.

- Treatment by someone other than a dentist, except for the scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist under the supervision and guidance of a dentist in accordance with generally accepted dental standards.

- Those services and benefits excluded by the rules and regulations of Delta Dental, including the processing policies, which may change periodically.

- Services or supplies for which no charge is made, for which the Patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage.

- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

- Services that are covered under a hospital, surgical/medical or prescription drug program.

- Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

Limitations

The benefits provided by Delta Dental for the following services are limited as follows. For the purpose of this Plan, all time limitations are to be measured from the date on which those services were last supplied under any Delta Dental plan.

- Benefits for prophylaxes and oral exams are payable twice in any period of 12 consecutive months.

- Benefits for bitewing X-rays are payable once in any period of 12 consecutive months. Benefits for full mouth X- rays (which include bitewing X-rays) are payable once in any five-year period. A panographic X-ray (including bitewings) is considered a full mouth X-ray and is paid as such.

- Benefits for cast restorations, including jackets, crowns, onlays and associated procedures such as cores and post substructures, on the same tooth are payable once in any five-year period.

- Benefits for porcelain, porcelain substrate and cast restorations are not payable for eligible Children under 12 years of age.

- Optional treatment: In all cases in which the Participant, Spouse or Child selects a more expensive service than is customarily provided or for which Delta Dental does not believe a valid dental need is shown, Delta Dental will pay only the applicable percentage of the fee for the service, if any, that is customarily provided.

- For example, if a tooth can be satisfactorily restored with amalgam and you choose to have the tooth restored with a more costly material, the plan will pay only the applicable amount that it would have paid to restore the tooth with amalgam. You are responsible for the difference in cost.

- Benefits for root planing are payable once in any two-year period. Benefits for periodontal surgery, including sub-gingival curettage, are payable once in any three-year period.

- Prosthodontic (Class 2) Benefit limitations:

  - Benefits for one complete upper and one complete lower denture are payable once in any five-year period for any individual.
  - Benefits for a partial denture, fixed bridge or removable bridge for any individual are payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
  - Benefits for fixed bridges and removable cast partials are not payable for people under 16 years of age.

- Benefits for topically applied fluorides are payable for Children until their 19th birthday.

- Our obligation for payment of benefits ends on the last day of the month in which an individual becomes ineligible for benefits.

- When services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each dentist.

- Care terminated due to death of a Participant, Spouse or Child will be paid in full, to the limit of the Plan's liability, for the services completed or in progress.

- The maximum benefit payable in any one contract year or any portion thereof will be limited to $800 per person (age 19 or older) total on Class 1 and Class 2 Benefits.

- Processing policies, which may change periodically, may limit treatment.

Contacting Delta Dental

You may access Delta Dental's website at deltadentalmi.com in order to:

- Print membership cards.

- Print an EOB.

- Check the status of a claim.

- To obtain a list of Participating Provider dentists.

SECTION 24

MAGELLAN HRSC INC. - EMPLOYEE ASSISTANCE PROGRAM (EAP)

We have arranged a further health benefit service to assist you and anyone living in your family household in dealing with emotional, marital, substance use disorder, financial, legal, family and work difficulties that may be encountered. It is recognized that daily living concerns/issues may, without professional assistance, sometimes lead to serious problems that can even involve substance use disorder or mental health conditions.

The Plan has contracted with Magellan HRSC, Inc. (Magellan) to provide to you as a Participant, or a member of your household, telephone contact with specially trained personnel to talk to you about your difficulty, and if necessary following a telephone contact, give you a referral to a qualified professional resource to help you with the particular situation. This program is referred to as an Employee Assistance Program (EAP).

Eligibility

Who is eligible for the Magellan coverage?

The assistance that the Magellan EAP Program provides is somewhat different and more comprehensive than your medical/hospital benefits, and is focused on members of your immediate household. Therefore, you as a Participant and anyone living in your household are eligible for the EAP Program.

Kind of Help

Specifically, what kind of help do I get from this EAP Program, and how do I get it?

You or a member of your family household may call by telephone a Magellan specialist at 1-800-724-PIPE (7473) to discuss your particular problem. This specialist will review your situation with you, make a clinical assessment of the help you need, if you need help, and will refer you to a trained professional clinician who is part of the Magellan network, or will refer you to an appropriate community-based resource. You may visit this clinician or go to the community-based resource personally and work with them to help resolve your difficulties.

Frequency of Use

How often may I use this telephone and personal consultation?

You and each household member may call by telephone any number of times 24 hours a day, 7 days a week. Personal visits through Magellan Health Services to a professional clinician who is part of their network are limited to **five times per calendar year per covered person in your household**. One person cannot use the allocation of another person in the household coverage unit. Visits to a community-based resource are not limited, even if referred by Magellan, but read the next paragraph about possible charges from that agency.

Cost

Is there a cost to me for this telephone and personal consultation?

No, not for any telephone consultation with the Magellan representative, or up to five personal visits per covered person with a referred professional clinician per calendar year. If you obtain other professional help beyond these five visits, even through a reference from Magellan, other than to a free community-based resource, you will need to check whether or not it is covered by the other coverages of the Plan, because otherwise you will be responsible for the payment. Please recognize that all community-based resources are not free, and even if you go there as a result of a Magellan referral, their charges are not covered in this EAP Program. The five free visits per year covered by the EAP Program are to clinicians who are part of the Magellan network.

Privacy

Since this subject might involve behavior that is very personal and private, or even substance use disorder, can we be assured of confidentiality if we call a Magellan representative?

Yes. Our contract with Magellan specifically provides for the confidential relationship of providing a health benefit.

Situations Covered

What kind of situation is included in this Benefit?

You, your Spouse, or Children may call concerning any emotional or behavioral problem being experienced by you or a member of your household. Representative situations that would be covered include:

Alcohol/Drug

Alcohol Dependency/Substance Use Disorder
Drug Dependency/Substance Use Disorder
Prescription Drug Use Disorder
Family Alcohol or Drug Co-Dependency

Family Relationship Concerns

Domestic Violence
Child Abuse or Neglect
Separation or Divorce Adjustment
Single Parenting
Step-Parenting
Teenage Adjustment
Parent-Child Relationships
Value of Role Conflicts

Behavioral Concerns

Gambling
Phobias
Smoking
Eating
Lying
Spending

Personal Emotional Concerns

Anxiety Reactions
Stress
Anger Management
Depression
Suicidal Thoughts
Chronic or Terminal Illness
Sexual Concerns
Post Traumatic Stress Issues
Guilt
Fear or Insecurity
Loss or Grief
Legal Issues

Occupational Adjustment

Job Adjustment Concerns
Retirement
Career Changes
Promotion
Relocation

Work and Family Life Issues

Planning and Outplacement
Impact of New Technology
Communication/Group Dynamics
Team Building/Managing Change
Human Resources
Policy/Planning
Crisis/Grief Intervention
Elder Care Planning
Child Care Planning

What if I have questions regarding the specific services offered?

Please call the toll free line, 1-800-724-PIPE (7473) and ask the Magellan representative.

Can my Magellan coverage be terminated?

Your coverage, as with all aspects of the Plan, may be terminated if the Trustees eliminate or change the Plan, or if you lose eligibility for the Plan. Your coverage will terminate the last day of the month in which either of these situations occur.

SECTION 25

DEFINITIONS

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

Actively At Work - A Member who is not disabled, who is not retired, and who is working under the jurisdiction of UA Local 190 Plumbers/ Pipefitters/ Service Technicians/ Gas Distribution.

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

Acute Care Facility - A facility that 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 Use Disorder treatment.

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

Administrator - See definition for Plan Administrator.

Administrative Manager - The person or organization appointed by the Board of Trustees to administer day-to-day activities of the Plan and Trust.

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

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.

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

Approved Amount - The provider's billed charge for the covered service, or the maximum payment level allowed by the insurance or other company administering the benefits, whichever is lower.

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.

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 or an affiliate of Blue Cross Blue Shield.

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

Assigned Claim – A claim for services provided by a Medicare participating provider or another provider that has accepted assignment on a claim. These providers have agreed to accept the Medicare approved amount as full payment.

Attending Physician - The physician in charge of a case who exercises overall responsibility for the patient's care.

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

Autism Evaluation Center - An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. The autism evaluation center must be approved by BCBSM to:

- Evaluate and **diagnose** the member as having one of the covered autism spectrum disorders and
- Recommend an initial high-level treatment plan for members with autism spectrum disorders.

Autism Spectrum Disorders - Autism spectrum disorders include Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

Basic Benefits - The benefits administered by Blue Cross Blue Shield pursuant to its contract with the Plan.

BCBSM – Blue Cross Blue Shield of Michigan.

Behavioral Health Treatment - Evidence-based counseling and treatment programs, including applied behavior analysis, which meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

Beneficiary - The person you have designated to receive the resources of the Fund after your death, or any person designated by a covered person to receive that covered person's benefit.

Benefit - Payment for health care services available in accordance with the terms of your health care coverage.

BlueCard Participating Provider - A provider who participates with the Host Plan.

Blue Cross Blue Shield Association - An association of independent Blue Cross 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 - 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.

Board Certified Behavior Analyst - An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.

Note: Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

Board of Trustees - The Trustees elected or appointed by labor and management to adopt and administer the Plan and Trust.

Carrier - An insurance company that provides a health care plan for its members.

Certified Registered Nurse Anesthetist - A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan, and
- Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing, and
- Meets Blue Cross Blue Shield qualification standards, and
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed

Child – Effective January 1, 2014, your biological or adopted child, or the child of the person to whom you are legally married during the period you are legally married, up to age 26. Prior to January 1, 2014, only children from the age of 19 through 26 who were not eligible for other employment-based coverage, other than through a parent met the definition of "child." Effective June 1, 2012, an adopted child includes your legally adopted child or a child who is lawfully placed with you for legal adoption by you.

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

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

COBRA (Consolidated Omnibus Reconciliation Act of 1985) - The continuation of health coverage upon satisfying a qualifying event within the meaning of Section 4980B of the Code.

Code - The Internal Revenue Code of 1986, as amended from time to time.

Co-insurance- Under Standard Coverage, the designated percentage of the Approved Amount you are required to pay for Covered Services.

Contracting Dentist - A dentist who has agreed to participate with Delta Dental Plan of Michigan and to accept its rules and fees.

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

Co-payment – Under Enhanced Coverage, the designated portion of the Approved Amount you are required to pay for Covered Services, either as a percentage or flat dollar amount. Under Standard Coverage, the designated flat dollar amount of the Approved Amount you are required to pay for Covered Services.

Covered Person - A Participant, Spouse or Child currently entitled to the benefits of the Plan.

Covered Services - Services, treatments or supplies identified as payable by the Plan. Covered services must be a medical necessity 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 medical services before the Plan begins to pay.

Designated Facility - To be a covered benefit, human organ transplants must take place in a "Blue Cross Blue Shield-designated" facility. A designated facility is one that Blue Cross Blue Shield determines to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to you and your physician upon request.

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.

Early Retiree - A Participant who retires prior to age 60.

Employer - An employer bound by the collective bargaining agreement with Local 190 United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada (also referred to as "Local 190"). With respect to employees of Local 190, Local 190 is considered an "Employer." Certain Fringe Benefit Funds established pursuant to collective bargaining agreements with Local 190 may also be considered "Employers" with respect to their employees.

ERISA - The Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulations issued pursuant to ERISA.

ESRD - End Stage Renal Disease; permanent kidney failure which requires a regular course of dialysis or a kidney transplant.

Evaluation - An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

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 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 use disorder treatment rehabilitation, skilled nursing care or physical therapy.

Fund - The Trust providing all benefits under the Plan, jointly established and administered by the Trustees.

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

Hospital - A facility that provides inpatient diagnostic 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.

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

Independent Physical Therapist - A licensed physical therapist who 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.

Line Therapy - Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

Lobar Lung - A portion of a lung from a cadaver or living donor.

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

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 or **Medically Necessary** - A service must be medically necessary in order to be payable by your health care coverage. Medical necessity definitions for hospital services and medical services follow.

Medical necessity for **hospital services** requires that:

- The service is for 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.
- The services are not mainly for the convenience of the Participant or health care provider.
- Blue Cross Blue Shield does not generally regard the treatment as experimental or investigative.

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

- The 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 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 Participant or physician.

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

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

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

Medicare-Eligible Retiree – A retired Member who is age 65 or older.

Member - A person who is a member in good standing of Local 190, or is eligible for participation in the Plan under Plan provisions.

Miscellaneous Benefits - The benefits awarded directly by the Fund such as vision, uninsured medical expenses (excluding co-pays) and uninsured dental (including co-pays), as specifically provided in Section 10.

Non-Bargaining Unit Employee - An employee of an Employer who is neither a Member, nor employed in the capacity as an executive or officer of such Employer.

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

Participant - Any active or retired person who is or was employed by an Employer and who is covered by the Plan.

Participating Providers - Providers that have signed participation agreements with Blue Cross Blue Shield agreeing to accept the Blue Cross Blue Shield approved amount for covered services as payment in full on a per claim basis.

Patient - The Participant or eligible Spouse or Child who is awaiting or receiving medical care and treatment.

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).

Plan - The UA Local 190 Health and Welfare Plan and/or the UA Local 190 Individual HRA Plan, as amended or restated from time to time.

Plan Administrator - The person who is responsible for the performance of all reporting requirements and disclosure obligations as described in ERISA. The Plan Administrator is the Board of Trustees.

Plan Year - The twelve-month period beginning June 1 and ending on the subsequent May 31.

Presurgical Consultation – The second and third visits with a physician other than the physician who initially recommends surgery, who is a doctor of medicine, osteopathy, podiatry or an oral surgeon. The purpose of a visit after the initial visit is to confirm the necessity of surgery and determine the medical tolerance for the proposed surgery.

Prior Authorization Process - A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine month intervals or at other mutually agreed upon intervals after the onset of treatment.

Professional Provider - One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Fully licensed psychologist
- Clinical licensed master's social worker
- Oral surgeon
- Board certified behavior analyst
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

Prosthetic Device - An artificial appliance that:

- Replaces all or part of a body part, or

- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ.

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

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

Registered Provider - A participating or nonparticipating provider that is an in-network or out-of-network PPO provider that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

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

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

Skilled Nursing Facility - A facility that provides continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility must have a written agreement with Blue Cross Blue Shield to provide benefits under the Plan.

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.

Spouse - The person to whom you are currently legally married.

Substance Use Disorder - Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic wellbeing.
- Cause the person to lose self-control.
- Endanger the safety or welfare of others because of the substance's habitual influence on the person.
- Substance abuse is alcohol or drug abuse or dependence as classified in Categories 303.2 through 305.0 and 305.2 through 305.9 of the most current edition of "International Classification of Diseases."

Surviving Spouse - A widow or widower of a deceased Participant for the period that she or he remains unmarried.

Totally and Permanently Disabled Participant - A Participant who is no longer able to perform the duties of his or her job or occupation, anticipated to be a permanent condition, as described in the UA Local 190 Pension Plan.

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

Treatment Plan for Autism Disorders - A written, comprehensive, and individualized plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at three, six and/or nine months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

- The approved autism evaluation center will recommend an initial high-level treatment plan.
- The board certified behavior analyst will develop a detailed treatment plan specific to applied behavior analysis treatment.

Trust - The UA Local 190 Health and Welfare Trust and/or the UA Local 190 Individual HRA Trust, which are the depository of all Employer contributions and the source of all benefit payments.

Trust Fund - The trust funds providing all benefits under the Plans, jointly established and administered by the Trustees.

Trustees - The Trustees elected by labor and appointed by management to adopt and administer the Plan and Trust. Also known as the Board of Trustees or Joint Board of Trustees.

Unassigned Claim – A claim for a service for which the provider has not agreed to accept the Medicare approved amount as payment in full.

You and Your - used when referring to any person covered under this Plan.

BLUE CROSS BLUE SHIELD

When calling or visiting, please know your contract number from your Blue Cross Blue Shield ID card.

Statewide Customer Service Phone Numbers

Monday through Friday 8:30 a.m.-noon and 1:00 p.m.-5:00 p.m.

Blue Cross Blue Shield Customer
Service Center for
UA Local 190
Health and Welfare Fund (877) 790-2583

Hearing and Speech Impaired

Area Code 313 or 810 (313) 225-6903 or (313) 225-4028
Area Code 616 (616) 285-2114 or (800) 867-8980

These phone numbers are <u>not</u> for Medicare inquiries.

Special Servicing Numbers

Anti-Fraud Hotline (in Michigan) (800) 482-3787
Anti-Fraud Hotline (outside of Michigan) (313)225-8100

BlueHealthConnection (800) 775-2583

Address for Written Inquiries:

Major Groups Customer Service
Blue Cross Blue Shield
600 Lafayette East, Department #0204
Detroit, Michigan 48226

In addition, Blue Cross Blue Shield provides the following additional information regarding how to contact Blue Cross Blue Shield:

How to Reach Blue Cross Blue Shield

This section lists phone numbers and addresses to help you get information quickly. You may call Blue Cross Blue Shield or visit Blue Cross Blue Shield's centers.

To Call

Most of Blue Cross Blue Shield's customer service lines are open for calls between 8:30 a.m. and noon and from 1 p.m. to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call. (The contract number is usually the subscriber's nine-digit social security number.)

Area Code 248, 313, 586, 734, 810 or 947
Detroit..... (313) 225-8100
Southeast Michigan Toll-free ..... (800) 637-2227

Area Code 231, 269 or 616
West Michigan Toll-free..... (800) 972-9797

Area Code 517 or 989
Central Michigan Toll-free ..... (800) 258-8000

Area Code 906
Marquette ..... (906) 228-9112
Upper Peninsula Toll-free ..... (800) 562-7884

To Visit

Blue Cross Blue Shield customer service centers are located throughout Michigan. Check the following list to find the center nearest you. Unless stated otherwise, the centers are open from 8:30 a.m. until 5 p.m., Monday through Friday.

Alpena
135 W. Chisholm Street, Alpena 49707
On the main street in downtown Alpena

Detroit
500 East Lafayette Boulevard, Detroit 48226
Downtown, two blocks north of Jefferson at I-375
Open from 8:30 a.m. to 4:30 p.m.

Flint
4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids
86 Monroe Center, NW, Grand Rapids 49503
Open from 8:0 a.m. to 6 p.m.

Holland
259 Hoover Boulevard, Suite 180, Holland 49423
Near U.S. 31 and 8th Street

Jackson
2282 Springport Road, Suite H, Jackson 49212
In Springport Center, ½ mile west of U.S. 127
Open from 8:30 a.m. to noon and from 1 p.m. to 5 p.m.

Lansing
1405 Creyts Road, Lansing 48917
¼ mile south of I-496, Creyts Road exit
Open from 8:30 a.m. to 4:30 p.m.

Marquette
415 S. McClellan Avenue, Marquette 49855
Up on the hill

Mt. Pleasant
1620 South Mission, Mt. Pleasant 48858
In the Campus Court shopping mall
Open from 8:30 a.m. to 12:30 p.m. and from 1:30 p.m. to 5 p.m.

Muskegon
1034 E. Sternberg Road, Muskegon 49444
The Pointes Mall

Portage
2255 W. Centre Avenue, Portage 49024
1 mile east of Centre Avenue exit off Route 131 at Oakland Drive (next to Bank One)

Port Huron
1924 Pine Grove Avenue, Port Huron 48060
Behind Global Insurance

Saginaw
4300 Fashion Square Boulevard, Saginaw 48603
¼ mile south of the Fashion Square Mall

Traverse City
1769 S. Garfield Avenue, Traverse City 49686
Across from Cherryland Center

Utica
6100 Auburn Road, Utica 48317
Diagonally across from the AAA Building

Administrative Manager:

TIC International Corporation
Attention: James Schreiber
30700 Telegraph Rd., Ste. 2400
Bingham Famrs, Michigan 48025

1-888-390-PIPE (7473)

I:\CL\9802\HEALTH\1 SPD-Plan

IMPORTANT CHANGES TO THE UA LOCAL 190 HEALTH AND WELFARE PLAN AND THE UA LOCAL 190 MEDICARE RETIREE HEALTH AND WELFARE PLAN ("PLANS")

Effective January 1, 2019, the following changes are being made to the Plans:

- Enhanced Dental Coverage is provided;
- Insured Vision Coverage is added;
- Miscellaneous Benefits are reduced to $1,000 per calendar year;
- Prescription Medicine Benefits are increased to $2,000 per calendar year; and
- Vision Insurance will be the sole source of coverage for vision benefits, and you will no longer be able to submit vision claims for reimbursement from the Miscellaneous Benefit or the Individual HRA Benefit.
- As provided under the Plans prior to these changes, expenses are reimbursable under the Miscellaneous Benefit (and under the Individual HRA Plan for expenses *other than* self-pay contributions in order to maintain coverage under the Plans or payments for other medical coverage for you, your Spouse or Children after retirement, after the annual Miscellaneous Benefit has been used up) only if the expenses are paid for the diagnosis, cure, mitigation (lessening), treatment, or prevention of a specific disease or for treatments affecting a specific part or function of the body. The expenses must be primarily to relieve or prevent a specific physical or mental defect or illness. Expenses that qualify and do not qualify for this deduction are listed and explained in IRS Publication 502. The Plan Administrator will look to Publication 502 and other IRS guidance to determine what is and is not an eligible expense.

Please see the attached for details.

UA LOCAL 190 HEALTH AND WELFARE PLAN

UA LOCAL 190 MEDICARE RETIREE HEALTH AND WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATIONS

NOTICE OF PLAN CHANGES

IMPORTANT NOTICE: Effective January 1, 2019, the UA Local 190 Health and Welfare Plan and UA Local 190 Medicare Retiree Health and Welfare Plan ("Plans") have been amended to enhance dental coverage, add insured vision coverage and modify the procedures for having dental expenses reimbursed under the Miscellaneous Benefit.

Coinciding with these changes and in connection with the renewal in annual limits for the Miscellaneous Benefit and Prescription Medicine Benefit, the amounts allocated for each of these benefits is changing.

This summary of material modifications explains the changes in the Plans and supplements the Summary Plan Description ("SPD") for the Plans. Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Administrator at the address or phone number listed at the end of the SPD.

How is Dental Coverage Changing?

Enhancement of Dental Coverage administered by Delta Dental. Prior to January 1, 2019, the Plans paid 50% of the Approved Amount of most basic dental services, including diagnostic and preventive services and emergency palliative treatment, and prosthodontic services, up to a cumulative amount of $800 per covered person per calendar year.

Effective January 1, 2019, dental benefits are improved and organized into four classes of benefits as follows, <u>provided you use a Contracting Dentist</u>:

Class 1 Benefits that are covered, paid at 100% of the Approved Amount; Class 1 Benefits do not count against the annual maximum of $1,500 per covered individual*:

- **Diagnostic and Preventive Services.** Prophylaxes (cleanings), examinations and fluoride.
- **Emergency Palliative Treatment.** To temporarily relieve pain.
- **Sealants**. To prevent decay of permanent teeth.
- **Radiographs.** X-rays.
- **Brush Biopsy**. To detect oral cancer.

Class 2 Benefits that are covered, paid at 80% of the Approved Amount, subject to an annual limit of $1,500 per covered individual*:

- **Oral Surgery Services.** Extractions and dental surgery.
- **Endodontic Services.** Root canals.
- **Periodontic Services.** To treat gum disease.
- **Relines and Repairs.** To bridges, implants and dentures.
- **Minor Restorative Services.** Fillings and crown repair.

Class 3 Benefits that are covered, paid at 50% of the Approved Amount, subject to an annual limit of $1,500 per covered individual*:

- **Major Restorative Services**. Crowns.
- **Prosthodontic Services.** Bridges and dentures.

Class 4 Benefits that are covered, paid at 50% of the Approved Amount, subject to a lifetime limit of $1,500 per covered individual; coverage is provided up to age 19*:

- **Pediatric Orthodontic Services.** Braces.

When you do not use a Contracting Dentist, the above-referenced percentages indicate the portion of the Delta Dental Nonparticipating Dentist Fee that will be paid for those services. For example, if you do not use a Contracting Dentist, coverage is limited to the following:

- ***100% of the Delta Dental Nonparticipating Dentist Fee*** **for Diagnostic and Preventive Services, Emergency Palliative Treatment, Sealants, Radiographs and Brush Biopsy;**
- ***80% of the Delta Dental Nonparticipating Dentist Fee*** **for Oral Surgery Services, Endodontic Services, Periodontic Services, Relines and Repairs; and**
- ***50% of the Delta Dental Nonparticipating Dentist Fee*** **for Major Restorative Services, Prosthodontic Services and Pediatric Orthodontic Services.**

The above amounts may be less than what the dentist charges and you are responsible for the difference. This is sometimes referred to as "balance billing."

***No annual limit applies to pediatric dental services (services for Children through the age of 18). However pediatric dental services are subject to applicable co-payment requirements.**

The dental coverage remains self-insured by the Plans.

How will the Plans provide vision coverage?

Addition of Insured Vision Benefit through EyeMed. Prior to January 1, 2019, the Plans did not offer vision coverage.

Effective January 1, 2019, the Plans provide insured vision coverage through EyeMed, as follows:

For in-network services, EyeMed pays:

> 100% of the Approved Amount for an eye exam, lenses (either contact lenses or lenses for a glasses frame) and frame every 12 months, with a $175 allowance for any available frame, plus 20% off the balance over $175. If you choose contact lenses, disposable contact lenses are covered at $175 every 12 months, with 15% off of the balance over $175; if you choose glasses, single vision, bifocal, or trifocal standard plastic lenses are covered at no cost.

As with medical and dental coverage, it is important to use participating providers, or "Contracting Vision Provider," in order to receive the maximum benefit.

For out-of-network services, EyeMed reimburses up to:

> $40 for an eye exam, up to $123 for frames, up to $175 for contact lenses, up to $30 for single vision standard plastic lenses, up to $50 for bifocal standard plastic lenses and up to $70 for trifocal standard plastic lenses.

How will vision expenses be paid?

Please note that effective January 1, 2019, EyeMed is the sole source of coverage for vision benefits. **Effective January 1, 2019, you may no longer submit vision claims for reimbursement from the Miscellaneous Benefit or Individual HRA Benefit AND you may no longer use the Wex Health Card to pay for vision expenses under the Plans.**

How are the Miscellaneous Benefit and Prescription Medicine Benefit Changing?

Changes in Miscellaneous Benefit and Prescription Medicine Benefit. Each January 1, the annual amount allocated to the Miscellaneous Benefit and the Prescription Medicine Benefit renews. Prior to January 1, 2019, the annual limit for the Miscellaneous Benefit was $1,800 and the annual limit for the Prescription Medicine Benefit was $1,440. Effective January 1, 2019, these benefits are renewed in the following amounts:

- **Miscellaneous Benefit: $1,000***

- **Prescription Medicine Benefit: $2,000**

*Effective January 1, 2019, claims for vision expenses may not be reimbursed through the Miscellaneous Benefit.

IMPORTANT CHANGES TO THE UA LOCAL 190 HEALTH AND WELFARE PLAN AND THE UA LOCAL 190 MEDICARE RETIREE HEALTH AND WELFARE PLAN

The Joint Board of Trustees of the UA Local Health and Welfare Plan and UA Local 190 Medicare Retiree Health and Welfare Plan ("UA Local 190 Plan") have decided to improve the retiree package by implementing a fully-insured Medicare Advantage Plan that includes Medicare Part D prescription coverage that is considered to be better than the limited prescription reimbursement account currently in place. Coupled together with the Medicare Advantage Plan will be:

- Dental coverage administered through Delta Dental;
- Vision coverage insured through EyeMed;
- $1,000 of Miscellaneous Benefits per calendar year; and
- For 2020, $2,000 of Prescription Medicine Benefits per calendar year to help cover copays imposed under the prescription coverage offered under the Medicare Advantage Plan.

EFFECTIVE JANUARY 1, 2020, THE ABOVE IS THE <u>ONLY</u> OPTION THAT MEDICARE-ELIGIBLE RETIREES RESIDING IN THE UNITED STATES WILL HAVE UNDER THE UA LOCAL 190 PLAN.

Federal law requires that the UA Local 190 Plan give you the right to "opt out" of the Medicare Advantage Plan that will be offered under the UA Local 190 Plan. You will be receiving a notice and "Opt-Out Form" giving you that right. If you do not want to be in the UA Local 190 Medicare Advantage Plan, you must "Opt-Out" using the Medicare Plus Blue Opt-Out Form that will be sent to you in November of 2019 and you will be out of the UA Local 190 Plan.

BUT, this is an "all-or-nothing" choice: **if you opt out** of the Medicare Advantage Plan offered under the UA Local 190 Plan, **you will also lose ALL of the following extra benefits and you will NOT be eligible to rejoin the UA Local 190 Retiree Plan in the future:**

- Dental coverage administered through Delta Dental;
- Vision coverage insured through EyeMed;
- $1,000 of Miscellaneous Benefits per calendar year; and
- The supplemental Prescription Medicine Benefits per calendar year ($2,000 for 2020).

If you are Medicare-eligible, and you want to continue to get all of these coverages from the UA Local 190 Plan, **DON'T opt out.** You will then be automatically enrolled in the Medicare Advantage Plan coverage under the Plans effective January 1, 2020.

Note that when your UA Local 190 Medicare Advantage coverage starts January 1, 2020, you will be automatically disenrolled from any other Medicare Advantage plan and/or any individual Medicare drug plan in which you are enrolled. This is because you cannot have more than one Medicare Advantage Plan and cannot have a Medicare Advantage Plan and separate, individual Medicare Part D (prescription) coverage.

Medicare Advantage Plans are health plans that are approved by Medicare and that are administered by private insurance companies. Medicare Advantage Plans provide all of your original Medicare Part A (hospital) and Medicare Part B (medical) benefits, and offer supplemental benefits not covered under original Medicare. In addition, the Medicare Advantage Plan offered under the Plans includes Part D coverage.

If you have a Medicare-eligible spouse and/or dependent(s) who do not wish to be enrolled in the Medicare Advantage Plan, you must complete the "Opt-Out Form" and indicate that you wish to join the UA Local 190 Plans Medicare Advantage Plan, but that you wish to remove those Medicare-eligible dependents that you list on the form. If your Medicare-eligible spouse and/or dependents opt out of the Local 190 Plan Medicare Advantage Plan, they will have NO coverage under the UA Local 190 Plan.

If you, as the member and contract holder, decide to opt out of the Medicare Advantage Plan offered under the UA Local 190 Plans, all covered, Medicare-eligible spouses and dependents will also be removed from the Medicare Advantage Plan offered under the UA Local 190 Plans. If you, as a Medicare-eligible Retiree residing in the United States opt out of the UA Local 190 Medicare Advantage Plan, you will have NO coverage under the UA Local 190 Plan.

Please note that if you are enrolled in the UA Local 190 Plans and subsequently enroll in an individual Medicare plan, or another Medicare Advantage Plan, you will lose coverage under the Medicare Advantage Plan offered under the UA Local 190 Plans and may not be able to re-enroll in the coverage offered under the UA Local 190 Plans.

If your spouse and/or your dependents are not Medicare-eligible, they will NOT be added to the Medicare Advantage Plan (even though you are added to the Medicare Advantage Plan) and their benefits will continue to be provided pursuant to the provisions of the UA Local 190 Plans for non-Medicare-eligible members, spouses and dependents.

Informational Meetings to be Held

Please note that informational meetings will be held at the Union Hall regarding these changes on Tuesday, November 12, 2019 at 10:00am and Wednesday, November 13, 2019 at 10:00am. You need attend only one of these meetings; we are offering two separate dates in order to accommodate more Retirees.

Summary of Benefits under Medicare Plus Blue Group PPO, the Medicare Advantage Plan offered under the UA Local 190 Plans

The following services are offered after you pay a $100 deductible, subject to a $500 annual out-of-pocket maximum:

Hospital/Facility Services

- Inpatient Facility Services-deductible and out-of-pocket maximum apply
- Outpatient Facility Services-deductible and out-of-pocket maximum apply

Physician/Practitioner Services

- Office Visits/Online Visits/Consultations-$5 copay
- Chiropractic Services-$5 copay
- Specialist Services-$10 copay
- Urgent Care-$10 copay
- Facility Evaluation & Management Services-deductible and out-of-pocket maximum apply
- Psychiatric-Psychotherapy Services-$5 copay
- Surgical Services/Anesthesia Services/Cardiac Catheterization/Cardiovascular-Therapeutic Services-deductible and out-of-pocket maximum apply
- Other Physician Services-deductible and out-of-pocket maximum apply
- Preventive Services-no member cost-sharing

Emergency Services
$65 copay

Ambulance Services
deductible and out of pocket maximum apply

Durable Medical Equipment/Prosthetics and Orthotics and Supplies*
deductible and out of pocket maximum apply

Human Organ Transplants/Travel and Lodging associated with Human Organ Transplants
deductible and out-of-pocket maximum apply

Removal of caps for Outpatient Physical Therapy
deductible and out-of-pocket maximum apply

Foreign Travel
cost sharing is the same as if services were provided in the United States

Determination of Refractive State (Vision Test)
deducible and out-of-pocket maximum apply

Chiropractic Enhanced Services

- Approved Radiological-$5 copay
- Approved E&M-$5 copay
- Approved Physical Therapy-$5 copay

Home Infusion Therapy
no member cost-sharing

Hospice Care
no member cost-sharing

Private Duty Nursing
50% coinsurance; does not accumulate towards out-of-pocket maximum

Travel and Lodging associated with Human Organ Transplant Benefits
no member cost-sharing; $10,000 limit; must be at least 100 miles from home

Silver Sneakers Program
no member cost-sharing

Prescription Medicine Benefits**

- Tier 1 (Preferred Generic)-25% cost-sharing; $10 minimum copay/$100 maximum copay
- Tier 2 (Generic)-25% cost-sharing; $10 minimum copay/$100 maximum copay
- Tier 3 (Preferred Brand)-25% cost-sharing; $10 minimum copay/$100 maximum copay
- Tier 4 (Non-Preferred)-25% cost-sharing; $10 minimum copay/$100 maximum copay
- Tier 5 (Specialty) 25% cost-sharing; $10 minimum copay/$100 maximum copay

*Effective January 1, 2020 for Medicare-eligible Retirees, spouses and dependents, diabetic prescriptions are no longer covered at 100% and are subject to a copayment. In order to help account for this, the $2,000 per calendar year Prescription Medicine Benefit offered under the UA Local 190 Plans is also available to Medicare-eligible Retirees.

**Effective January 1, 2020 for Medicare-eligible Retirees, spouses and dependents, diabetic lancets and test strips are covered at 100% only if they are obtained by a durable medical equipment provider. If they are obtained at a pharmacy, they are subject to a copayment.

In addition to all of the above benefits, if you are covered by the UA Local 190 Medicare Advantage Plan, you also will keep the following benefits:

- Dental coverage administered through Delta Dental;
- Vision coverage insured through EyeMed;
- $1,000 of Miscellaneous Benefits per calendar year; and
- At least for 2020, $2,000 of Prescription Medicine Benefits per calendar year to help cover copays imposed under the prescription coverage offered under the Medicare Advantage Plan.

UA Local 190 Health and Welfare Plan

UA Local 190 Medicare Retiree Health and Welfare Plan

Notice of Health and Welfare Changes

Self-Pay Changes Effective March 1, 2019

Effective March 1, 2019, there will be changes to the self pay rates under the UA Local 190 Health and Welfare Plan and the UA Local 190 Medicare Retiree Health and Welfare Plan ("Plans"). These adjustments are necessary in relation with the cost increase trend and inflation that occurs in the health care industry.

These changes will help offset the climbing benefit costs, avoid deficit spending, and help ensure that the benefits will continue to be available for all members.

These changes are effective March 1, 2019.

Following is a brief summary of most of these changes. Also attached is an updated self pay rate chart for your Summary Plan Description. Please insert it into your Summary Plan Description binder.

Actives/COBRA

- The first 12 months of self-pay for an active participant who qualifies for the normal self-pay rate for months with fewer than 100 hours remains at the special reduced COBRA rate of $100 per month. After that, the rate increases to the regular COBRA rate.
- The regular COBRA rates in effect from March 1, 2019 through February 29, 2020 are:

COBRA, full coverage, single	$686
COBRA, full coverage, couple	$1,511
COBRA, full coverage, family	$1,957
COBRA, basic coverage, single	$666
COBRA, basic coverage, couple	$1,468
COBRA. Basic coverage, family	$1,901

- COBRA rates are adjusted each year as of March 1 based on the actual costs incurred by the Plans during the previous year.

Retirees Ages 55 – 60

- The rates in effect from March 1, 2019 through February 29, 2020 are:

Retiree, before age 60:	$564.60
Retiree, before age 60, with Spouse on Medicare:	$486.90

- Self pay rates will be adjusted annually each March 1, based on the percentage change in the single basic coverage COBRA rate.

Retirees Age 60 and Over

- The rates in effect from March 1, 2019 through February 29, 2020 are:

Retiree, age 60-64, to age 65:	$431.22
Retiree, age 60-64, with Spouse on Medicare, to age 65:	$347.03
Retiree, age 65 with Spouse not on Medicare:	$347.03
Retiree, age 65 with a family not on Medicare:	$431.22
Retiree, Spouse or surviving Spouse only, on Medicare:	$89.34 each

- Self pay rates will be adjusted annually each March 1, based on the percentage change in the single basic coverage COBRA rate.

Workers Compensation and Disability

- Effective June 1, 2011, self pay rates for members who are on workers' compensation are $100 per month for the first 12 months, $200 per month for the second 12 months and $300 per month for the third 12 months. After 36 months, you are no longer eligible for coverage.

- Self pay rates for members who are disabled but not on Pension Disability are the same self-pay rates that apply to active members - $100 per month for the initial 12 months, with the remaining period at the full COBRA rates.

- Self pay rates for members who are receiving Pension Plan Disability and are receiving Social Security Disability Income (SSDI) are the same as the rates for retirees aged 65 (with the same adjustments for coverage for spouse or family).

- Self pay rates in effect from March 1, 2019 through February 29, 2020 for members who are receiving Pension Plan Disability and are <u>not</u> receiving SSDI are as follows:

Member on Disability Pension, not receiving SSDI, single:	$161.87
Member on Disability Pension, not receiving SSDI, with spouse or family not on Medicare	$431.22
Member on Disability Pension, not receiving SSDI, with spouse on Medicare	$347.03

- Self pay rates for members who are receiving Pension Plan Disability and are not receiving SSDI will be adjusted annually each March 1, based on the percentage change in the single basic coverage COBRA rate.

Surviving Spouse with Family:	$467.48
Surviving Spouse without Family:	$340.57

If you have any questions regarding these changes, please contact Bernadette Maus at the Fund Office, 30700 Telegraph Rd., Ste. 2400 Bingham Farms, MI 48025, (888) 390-7473.

UA Local 190 Health and Welfare Plan

UA Local 190 Medicare Retiree Health and Welfare Plan

Notice of Health and Welfare Changes

Self-Pay Changes Effective March 1, 2018

Effective March 1, 2018, there will be changes to the self pay rates under the UA Local 190 Health and Welfare Plan and the UA Local 190 Medicare Retiree Health and Welfare Plan ("Plans"). These adjustments are necessary in relation with the cost increase trend and inflation that occurs in the health care industry.

These changes will help offset the climbing benefit costs, avoid deficit spending, and help ensure that the benefits will continue to be available for all members.

These changes are effective March 1, 2018.

Following is a brief summary of most of these changes. Also attached is an updated self pay rate chart for your Summary Plan Description. Please insert it into your Summary Plan Description binder.

Actives/COBRA

- The first 12 months of self-pay for an active participant who qualifies for the normal self-pay rate for months with fewer than 100 hours remains at the special reduced COBRA rate of $100 per month. After that, the rate increases to the regular COBRA rate.
- The regular COBRA rates in effect from March 1, 2018 through February 28, 2019 are:

COBRA, full coverage, single	$671
COBRA, full coverage, couple	$1,477
COBRA, full coverage, family	$1,914
COBRA, basic coverage, single	$650
COBRA, basic coverage, couple	$1,433
COBRA. Basic coverage, family	$1,856

- COBRA rates are adjusted each year as of March 1 based on the actual costs incurred by the Plans during the previous year.

Retirees Ages 55 – 60

- The rates in effect from March 1, 2018 through February 28, 2019 are:

Retiree, before age 60:	$551.37
Retiree, before age 60, with Spouse on Medicare:	$475.49

- Self pay rates will be adjusted annually each March 1, based on the percentage change in the single basic coverage COBRA rate.

Retirees Age 60 and Over

- The rates in effect from March 1, 2018 through February 28, 2019 are:

Retiree, age 60-64, to age 65:	$421.11
Retiree, age 60-64, with Spouse on Medicare, to age 65:	$338.90
Retiree, age 65 with Spouse not on Medicare:	$338.90
Retiree, age 65 with a family not on Medicare:	$421.11
Retiree, Spouse or surviving Spouse only, on Medicare:	$87.25 each

- Self pay rates will be adjusted annually each March 1, based on the percentage change in the single basic coverage COBRA rate.

Workers Compensation and Disability

- Effective June 1, 2011, self pay rates for members who are on workers' compensation are $100 per month for the first 12 months, $200 per month for the second 12 months and $300 per month for the third 12 months. After 36 months, you are no longer eligible for coverage.

- Self pay rates for members who are disabled but not on Pension Disability are the same self-pay rates that apply to active members - $100 per month for the initial 12 months, with the remaining period at the full COBRA rates.

- Self pay rates for members who are receiving Pension Plan Disability and are receiving Social Security Disability Income (SSDI) are the same as the rates for retirees aged 65 (with the same adjustments for coverage for spouse or family).

- Self pay rates in effect from March 1, 2018 through February 28, 2019 for members who are receiving Pension Plan Disability and are <u>not</u> receiving SSDI are as follows:

Member on Disability Pension, not receiving SSDI, single:	$158.08
Member on Disability Pension, not receiving SSDI, with spouse or family not on Medicare	$421.11
Member on Disability Pension, not receiving SSDI, with spouse on Medicare	$338.90

- Self pay rates for members who are receiving Pension Plan Disability and are not receiving SSDI will be adjusted annually each March 1, based on the percentage change in the single basic coverage COBRA rate.

Surviving Spouse with Family:	$456.52
Surviving Spouse without Family:	$332.59

If you have any questions regarding these changes, please contact Bernadette Maus at the Fund Office, 30700 Telegraph Rd., Ste. 2400 Bingham Farms, MI 48025, (888) 390-7473.

UA LOCAL 190 HEALTH AND WELFARE PLAN

UA LOCAL 190 MEDICARE RETIREE HEALTH AND WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATIONS

NOTICE OF PLAN CHANGES

IMPORTANT NOTICE: Effective April 1, 2018, the UA Local 190 Health and Welfare Plan and UA Local 190 Medicare Retiree Health and Welfare Plan ("Plans") have been amended to comply with final Department of Labor regulations on disability claims procedures. This summary of material modifications explains the changes in the Plans and supplements the Summary Plan Description ("SPD") for the Plans. Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Administrator at the address or phone number listed at the end of the SPD.

Changes in Claims Procedures Regarding Loss of Time Benefits. The Plans' claims procedures covering determinations regarding Loss of Time benefits are amended to comply with the following provisions, **effective April 1, 2018**:

- In the case of claims for Loss of Time benefits, you may not bring a lawsuit to recover benefits before completion of the Appeals Procedure and in no case before the expiration of 60 days after proof of loss has been filed in accordance with the notice requirements, unless the Plan fails to strictly adhere to all the requirements of this section with respect to a claim, other than *de minimis* violations that do not cause, and are not likely to cause you prejudice or harm so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may not bring a lawsuit after two years from the time within which proof of loss is required, or after the date identified in the notice of claim denial.

- Any decision regarding the hiring, compensation, termination, promotion, or similar matters with respect to any individual such as a claims adjudicator or medical expert (and in addition, a vocational expert in the case of Loss of Time claims) must not be based upon the likelihood that the individual will support the denial of benefits.

- In the case of a Loss of Time Claim Denial, the denial will include a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    - The views presented by you of health care professionals treating you and vocational professionals who evaluated you;

    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Claim Denial, without regard to whether the advice was relied upon in making the benefit determination; and

    - A disability determination made by the Social Security Administration regarding you and presented by you to the Plan.

- In the case of a Loss of Time Claim Denial based on a medical necessity or experimental treatment or similar exclusion or limit, the denial will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. In addition, the denial will include the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making a Claim Denial, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist. Lastly, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

- You will be provided the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. A document, record, or other information will be considered relevant to your claim if it was relied upon in making the benefit decision, or was submitted, considered, or generated in the course of making the benefit decision, regardless of whether it was relied upon in making the decision. The review of your appeal will take into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

- The Board of Trustees will make available the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claim Denial, regardless of whether the advice was relied upon in making the decision.

- Before the Board of Trustees can issue an appeal denial, it will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of appeal denial is required to be provided to you, so you have a reasonable opportunity to respond prior to that date. In addition, before the Board of Trustees can issue an appeal denial based on a new or additional rationale, they will provide you with the rationale. The rationale must be provide as soon as possible and sufficiently in advance of the date on which the notice of appeal denial is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

- In the case of a denial of appeal for Loss of Time Benefits, if applicable, the Board of Trustees will provide a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

  - the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;

  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Claim Denial, without regard to whether the advice was relied upon in making the Claim Denial; and

- a disability determination made by the Social Security Administration regarding you and presented by you to the Plan.

- In the case of a denial of appeal for Loss of Time Benefits based on a medical necessity or experimental treatment or similar exclusion or limit, the Board of Trustees will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- In the case of a denial of appeal for Loss of Time Benefits, the Board of Trustees will provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Claim Denial, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

- In the case of Loss of Time benefits, any retroactive termination of coverage whether or not there is an adverse effect on any particular benefit at that time, amounts to an adverse benefit determination subject to appeal, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

- In the case of Loss of Time Benefits, the notification of appeal denial will include a statement of any applicable statute of limitations that applies to your right to bring such an action, including the calendar date on which the statute of limitations expires for the Loss of Time claim.