

**Health Care Handbook**  
**for employees of**  
***Michigan Trucking, LLC***  
**PPO High Plan**

**Preferred Provider Organization (PPO)**

Including:

Prescription Drugs

Vision

## Blue Cross Blue Shield Customer Service Directory

We are committed to providing you with excellent customer service. When you have a question or need help, you can call a knowledgeable customer service representative or go to one of the Web sites listed below.

### Where to Call or Write for Customer Service:

When writing or calling, please provide your contract number from your Blue Cross Blue Shield ID card.

Telephone inquiries: 888-890-5707

**Note:** You can get information about your coverage 24 hours a day through our interactive voice response system by calling the telephone inquiry phone number. See the “General Information” section of this handbook for more information about the IVR system.

Written inquiries: Blue Cross Blue Shield of Michigan  
West Michigan Customer Service  
P.O. Box 230555  
Grand Rapids, MI 49523-0555

If you suspect fraud, call our fraud hotline: 800-482-3787

Write to the Anti-fraud unit: Anti-Fraud Unit — Mail Code B759  
Blue Cross Blue Shield of Michigan  
600 E. Lafayette Blvd.  
Detroit, MI 48226

Anti-fraud unit Website: [bcbsm.com/home/health\\_care\\_fraud](http://bcbsm.com/home/health_care_fraud)

### Prescription Drug Information:

Prescription drug inquiries: 888-890-5707

Medco home delivery inquiries: 800-778-0735

Web site: **medco.com**

Out-of-network claims: Medco  
P.O. Box 14711  
Lexington, KY 40512

Walgreen's  
(Specialty drugs) 866-515-1355

## Vision Service Plan

For customer service call: 800-877-7195

Or write to Customer Service  
Vision Service Plan  
P.O. Box 997100  
Sacramento, CA 95899-710

Visit the VSP Website: **vsp.com**

For VSP out of network claims: Out-of-Network Claims  
Vision Service Plan  
P.O. Box 997105  
Sacramento, CA 95899-7105

## Network Provider Locator:

800-810-BLUE (2583) **bcbs.com**

## Web Site Address:

Blue Cross Blue Shield of Michigan: **bcbsm.com** (and register for *Member Secured Services* so you can access all of our online services)

## Member Self Service

This feature allows you to check on a claim you sent to us, get up to date information on your deductibles and out of pocket expenses, view or print EOBs or order a BCBS ID card. You can also see the personalized resources that BlueHealthConnection® offers.

Visit my health care benefits **bcbsm.com** (and register for *Member Secured Services* so you can access all of our online services)

## BlueHealthConnection®

Your benefits include BlueHealthConnection, our personalized program designed to help you learn as much as you can about your health. When you have the health information you need, you can make better decisions, which will help you wherever you are.

BlueHealthConnection provides you with educational resources to help you understand and manage a disease and interactive Web resources where you can learn about your health and how to improve it.

Call 24 hours a day:

800-775-BLUE (2583)

**Or visit the BlueHealthConnection Web site:**

**bcbsm.com** (and register for *Member Secured Services* so you can access all of our online services)

## **Decision Support Resources**

Using Healthcare Advisor™, you can access a suite of Web-based resources designed to help you make more informed decisions about your health care. You can research doctors and hospitals, find the cost of common health care services, compare drug treatment options and much more.

To access Healthcare Advisor™, go to:  
Coverage Advisor™ is designed to help you find the type of health care plan that best fits your lifestyle.

[http://www.bcbsm.com/member/coverage\\_options/coverage\\_advisor.shtml](http://www.bcbsm.com/member/coverage_options/coverage_advisor.shtml)

To access Coverage Advisor, go to:

[http://www.bcbsm.com/member/coverage\\_options/coverage\\_advisor.shtml](http://www.bcbsm.com/member/coverage_options/coverage_advisor.shtml)

For more information on any of these resources, see the section “Making the Most of Your Health Care Plan.”

## Introduction

Blue Cross Blue Shield is pleased to provide you and your family with this handbook that explains your health care coverage. When you are well informed about your coverage and your health care benefits, you will have the confidence and security that come from knowing that health care coverage is available when you need it.

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

When you come across a word you don't understand, look in the Glossary at the back of the handbook. It contains the definitions of many words that you might not be familiar with.

This book is a handy reference. However, if you have questions that are not answered in the handbook, please contact a Blue Cross Blue Shield customer service representative.

*This handbook is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.*

*Blue Cross Blue Shield of Michigan administers the benefit plan **for your employer and** provides administrative claims payment services only. Blue Cross Blue Shield of Michigan does not insure the coverage nor do we assume any financial risk or obligation with respect to claims. Benefits and future changes in benefits are the responsibility of your employer. Information concerning members may be reviewed by **Blue Cross Blue Shield of Michigan, and may also be reviewed by your employer, on a limited basis, for specific purposes permitted by law.***

*The coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.*

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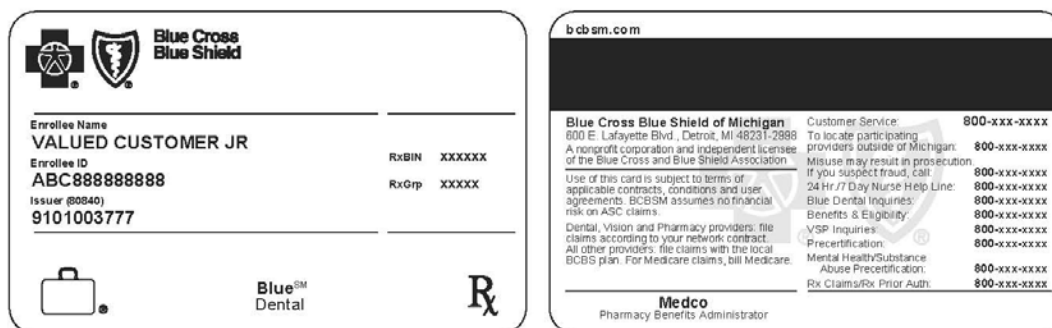
# Section 1: General Information

## Your Identification Card is Important

As an enrolled member of a Blue Cross Blue Shield plan, you receive your BCBS identification cards. Your ID cards allow you to obtain services covered under your health care plan. Only the subscriber's name appears on the ID cards. However, the cards are for use by all of the subscriber's eligible dependents.

The numbers on your ID card, especially the contract number, are very important in identifying your type of coverage. The contract number is the alpha numeric number found on your ID card. Here are some tips about your ID card:

- Make sure you carry the latest card. Using outdated cards may delay payment of claims.
- You may request additional cards, without cost, for your eligible dependents and replace lost or stolen cards by calling your BCBS customer service representative at the toll-free phone number listed on the inside front cover of this handbook. **You can also visit [bcbsm.com](http://bcbsm.com) (and register for Member Secured Services so you can access all of our online services) to order ID cards.**
- If your card is lost or stolen, you can still receive services, but you should report the loss of your card immediately to your employer or to your BCBS customer service representative.



## Preventing Fraud

BCBS tries to prevent fraudulent use of your ID card. Only you and your eligible dependents may use the cards issued for your health care plan. Lending your card to anyone not eligible to use it is illegal. Your health care provider may ask for identification other than your ID card. Checking identification helps prevent unauthorized use of your card. If you suspect health care fraud against BCBS, contact our Anti-Fraud Unit at the phone number or address listed on the inside front cover of this handbook. All inquiries are strictly confidential.

## Customer Service

If you have questions about your health care plan, please contact your BCBS customer service representative. For your convenience, we have listed our customer service phone numbers and addresses on the inside front cover of this handbook.

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

- Have your contract number ready. It is the alpha numeric number found on your BCBS ID card.
- In addition to your contract number, please provide a daytime telephone number.
- If you are questioning a service, please provide:
  - Patient's name
  - Date the patient was treated
  - Name of doctor or hospital
  - Type of service
  - Charge for **each** service
- When sending us bills, forms or other papers, please make copies of them. Send the originals to BCBS and keep the copies for your records. Make sure your contract number is on each page.

## **24/7 Customer Service**

When you have a question about claims, deductibles, maximum out of pocket expenses, coordination of benefits, whether a health care provider participates with your health plan, or you need an ID card, you can get the help you need by using our interactive voice response automated servicing system, available, 24 hours a day everyday. You are immediately connected to the system when you dial your customer service telephone number.

## Section 2: Eligibility Guidelines

When you are eligible to enroll for health care coverage, your employer will provide you with an application and assist you with the enrollment process. You may enroll your spouse and eligible dependents for whom you are responsible. To ensure that these records are kept up to date, you must promptly report any changes (birth of a newborn, change of address, marriage, etc.) to your employer. Guidelines for reporting changes are outlined later in this section. **(See additional eligibility information in Section 10 of this handbook.)**

### Health Care Coverage Eligibility Chart

Eligible Employee or Dependent	Qualification for coverage
Active employee	First of the month following 90 days of employment
Spouse	Date of marriage
Newborn	Date of birth
Dependent children	Coverage continues until their 19 <sup>th</sup> birthday
Dependent continuation coverage	Coverage continues until their 23 <sup>rd</sup> birthday <b>(students only)</b>
Disabled dependents	Must be disabled before they turn 19 and <b>you must notify BCBS by the end of the calendar year in which the dependent turns 19</b>

Please contact your benefits department for further information.

### Dependents

Eligible dependents include your spouse and any of your unmarried biological children. These dependents can include:

- **Adopted children** may be enrolled as of the date of final adoption or the date of a petition for adoption if the child resides with the subscriber and the subscriber notifies BCBSM. In either case, BCBSM must be notified within 30 days of the date of final adoption or the date of the petition for adoption. A copy of the petition for adoption must be submitted.
- **Dependent stepchildren** are eligible when a subscriber marries a spouse who has custody of dependent children. The subscriber must add the spouse and stepchildren within 30 days of the marriage. The coverage effective date for the spouse and stepchildren will be the date of marriage. If the spouse and dependent stepchildren are not added within 30 days of marriage, they can be added at your group's annual open enrollment period.

- **Children under legal guardianship** are eligible to enroll on a subscriber's contract as of the date legal guardianship is granted to the subscriber or prior to that if the subscriber has filed a petition for legal guardianship and the child has established residency with the subscriber. When notification is made within 30 days of the date of the event, coverage for the children will become effective as of the date of the event. One of two of the following documents is required:
  - A sworn statement that includes the date of petition for legal guardianship and the date the child established residency
  - A statement from the court verifying legal guardianship has been granted
- **Children eligible because a court order** puts responsibility for the dependents' health care on the subscriber or the spouse. The dependents are eligible for coverage immediately.

## Dependent Continuation Coverage

Dependents who meet the eligibility requirements listed below may continue to be covered under your contract as continuation members beyond the age of 19. You must apply for coverage by the time they turn 19 years old. Coverage for these dependents will be exactly the same as yours.

To be eligible, these dependents must meet **all** the following requirements:

- Be unmarried and between 19 and 23
- Be dependent on you for more than half of their support
- Be members of your household unless they reside elsewhere, as in the case of college students
- Be related to you by blood, marriage, legal adoption or legal guardianship
- Be full-time students for at least five months of the year

Effective for plan years beginning on or after October 9, 2009 (January 1, 2010 for calendar year plans), **Michelle's Law** prohibits a group health plan, or health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a "dependent child" due to a qualifying "medically necessary leave of absence" from, or other change in enrollment at, a postsecondary education institution prior to the earlier of:

- (i) the date that is one year after the first day of the medically necessary leave of absence; or
- (ii) the date on which such coverage would otherwise terminate under the terms of the group health plan

## Disabled Dependents

Disabled dependents are eligible for coverage under your contract to any age, if they are totally and permanently disabled by a certain age, and **you notify BCBS in writing of the condition** (see "Eligibility Chart" for age restrictions and notification requirements). The disability must be due to mental retardation or physical disability that prevents a dependent from being self-supporting. The subscriber must also report the child as a dependent on his or her most recent federal income tax return.

Disabled dependents must be unmarried and dependent on you for support and care in order to be covered. You may be required to provide verification of a dependent's total and permanent disability.

## **Working Families Tax Relief Act Definitions**

Under the Working Families Tax Relief Act of 2004, the IRS changed some of the requirements for dependents. The definitions for dependents set forth in this handbook are intended to meet these new requirements.

## **Special Enrollment Periods**

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future enroll yourself and your dependents in this plan, if:

- The other coverage is terminated as a result of loss of eligibility or termination of employer contributions for the other coverage, provided that you request enrollment within 30 days after your other coverage or the employer contribution toward that coverage ends. “Loss of eligibility” includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim.
- You have a new dependent as a result of marriage, birth, adoption, placement for adoption or legal guardianship, provided that you request enrollment within 30 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

If you declined enrollment because you had COBRA continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan under a special enrollment period. Otherwise, you must wait until the next annual open enrollment period.

## **Pre-existing Condition Exclusion**

A pre-existing condition exclusion is a limitation or exclusion of benefits relating to a physical or mental condition that was present before the first day of coverage. Your plan will not pay benefits for covered services rendered to treat such a condition until after the exclusion period ends.

If you have a pre-existing condition, we will not limit or exclude benefits for that condition unless medical advice, diagnosis, care or treatment was recommended or received within three months prior to your enrollment date. **Your enrollment date is your first day of coverage; or if your employer has a new hire waiting period, it is the first day of that waiting period.**

BCBS will take into account medical advice, diagnosis, care, or treatment for a pre-existing condition only if it is recommended by or received from an individual who is licensed or otherwise authorized under state law to provide such services and who is operating within his or her scope of practice.

Your employer will determine the maximum duration of the pre-existing exclusion period applicable to coverage under its group health plan. However, this period cannot extend for more than 12 months from enrollment.

When you enroll, you have a right to demonstrate to your employer that you have creditable coverage. Creditable coverage refers to prior days of coverage you have under another group health plan, public health plan, or other health insurance. Days of coverage that occur before a break of 63 or more days are not counted in determining how much creditable coverage you have.

If you have creditable coverage, your employer must reduce the pre-existing condition exclusion period under your plan by the number of days of creditable coverage you have as of the enrollment date.

Your employer will notify BCBS of the duration of your pre-existing condition exclusion period after considering how much creditable coverage you and your dependents possess, if any.

You have a right to request a certificate of creditable coverage from your prior group health plan or insurer if you need one. Your current employer can assist you, if necessary.

BCBS will not impose a pre-existing condition exclusion for:

- Newborns or children adopted before age 18 if they are enrolled within 30 days of birth or adoption. This rule will no longer apply to a child after a break of 63 or more days in the child's coverage.
- Pregnancy

## **Making Membership Changes — Your Responsibility**

It is important that your membership records be kept up-to-date so BCBS can process your claims quickly and correctly. Please report any changes to your employer promptly. Any changes involving adding or removing a dependent due to marriage, birth, divorce, dependent no longer eligible for coverage, etc., or changing an address must be made within 30 days of the change. You will be asked to complete a *Benefit Enrollment/Change* form. **If you do not complete and return the form within 30 days, the change will not become effective until the next annual enrollment period.** When you complete the *Benefit Enrollment/Change* form, be sure to fill in the names, dates and reasons for the change. Sign the form and return it promptly to your employer so that BCBS membership records can be adjusted.

## When Coverage Ends

The chart below gives the reason and the end date of coverage when removing dependents.

Dependent Type	Reason for Losing Coverage	Effective End Date of Coverage
Spouse	Divorce or legal separation	Date of divorce or legal separation
Dependent children	Marriage	Date of marriage
	Passed age of eligibility	19 <sup>th</sup> birthday, 23 <sup>rd</sup> birthday if full-time student

## Continuing Health Care Coverage on Your Own

When you are no longer eligible for health care coverage through your employer, coverage for you and your dependents ends. However, you may continue **temporary** coverage through your employer. This is called **COBRA continuation coverage**. A federal law requires employers of 20 or more people to offer a temporary extension of coverage to those who lose group coverage. This extension applies to the employee, spouse and dependent children including children born or adopted after you become eligible for COBRA who are enrolled within 60 days of the qualifying event. The person who lost the group coverage is called a "qualified beneficiary." To maintain coverage for the entire eligibility period, you (or your dependents) must pay the cost of coverage. Please contact your employer to clarify your eligibility.

**You are not eligible for individual group conversion coverage.**

## COBRA Continuation Coverage

Your employer will notify you and your dependents when you are eligible for this temporary extension of your health care coverage. In the case of your death, your employer must notify your dependents about their eligibility. In case of divorce, you or your former spouse must notify the employer within 60 days in order to be eligible for this coverage. In every case, you (or your dependents) must notify your employer within 60 days of your decision to continue coverage through your employer. The length of time this continuation coverage is available to you and your dependents depends on the reason you become eligible for this coverage. You or your dependents will be required to pay the entire applicable cost of coverage, plus an administrative fee.

## Employee Continuation Coverage

If you lose your coverage because of layoff, reduction in your hours of employment or termination of your employment (for other than gross misconduct), coverage is available to you and your dependents for up to 18 months.

Continuation coverage is extended to 29 months if:

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

### **Dependent Continuation Coverage**

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

- Your dependents' coverage under the plan ends due to your death.
- You become entitled to Medicare, and your spouse or dependents lose group coverage as a result.
- Divorce or legal separation causes a spouse to lose coverage.
- Children no longer meet dependent eligibility requirements under your plan.

### **Level of Coverage**

If you or your dependents choose COBRA continuation coverage through your employer, you will be offered the same level of benefits that active employees have.

You may continue the COBRA coverage you select until the earliest of the following situations:

- The end of your continuation period
- The date your employer no longer provides coverage to any of its employees
- The date you do not make payment for COBRA coverage
- The date you or your dependents become covered under another group health care plan (unless that plan includes exclusions or limitations about pre-existing conditions that apply to you)
- The date you or your dependents become entitled to Medicare

Additional COBRA information may be found in Section 10 of this handbook.

## **American Recovery and Reinvestment Act and COBRA**

Under the American Recovery and Reinvestment Act, you may be eligible for premium assistance for involuntary termination to help in paying for COBRA coverage. The subsidy is available to involuntarily terminated employees for up to 15 months. Qualified beneficiaries will pay 35 percent of the COBRA premium.

Eligible individuals who did not elect COBRA coverage or had coverage terminated due to non-payment of premium are granted a second election period of 60 days for coverage. Your employer is responsible for notifying eligible individuals of their second period for COBRA enrollment.

## **Children's Health Insurance Program Reauthorization Act (CHIPRA)**

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires all health plans to allow for a special enrollment period should you or your dependents lose eligibility under Medicaid or Children's Health Insurance Program (CHIP) coverage through states participating in a premium share subsidy to eligible participants.

You and your eligible dependents have 60 days to enroll in our group's health plan under the following two circumstances:

- If you or your eligible dependents' Medicaid or CHIP coverage is terminated due to loss of eligibility
- If you or your dependents become eligible for a premium assistance program in the state in which you reside.

If you are enrolled in such a program, your health plan will not accept direct payment from the state.

Your group health plan is primary to any coverage under CHIP.

## **Certificate of Creditable Coverage**

The Health Insurance Portability and Accountability Act of 1996 requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate states the amount of time that you had coverage with your employer. The rules for certificates of creditable coverage help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any pre-existing condition exclusion periods that might otherwise apply when changing to new coverage through a new employer or group.

When your coverage through your employer ends, you will receive a certificate of creditable coverage. You may also request a certificate for periods of coverage on and after July 1, 1996, within 24 months of loss of that coverage.

## **Section 3: Selecting a Health Care Provider**

Your benefits are provided through the preferred provider organization health care plan. This plan is designed to provide you the highest level of benefit payment and limit your out-of-pocket costs when you use physicians, hospitals and other health care specialists that are a part of the PPO health care provider network.

There are three levels of participation in the BCBS provider network. The level of a health care provider's participation impacts the costs for which you will be responsible. The three levels are:

- Network providers
- Out-of-network, but participating providers
- Nonparticipating providers

### **Network Providers**

To receive the highest benefit payment level, you should use health care providers within the PPO network. Network providers have signed agreements with BCBS, which means they agree to accept our approved payment, for a covered benefit, as payment in full. You will only pay for the deductibles, copayments and coinsurances required by your coverage.

Ask your physician if he or she participates with the BCBS PPO network in your plan area. If you need help locating a network provider, please call the phone number to locate a BCBS network provider or visit the Web site listed on the inside front cover of this handbook.

When you go to network providers, you do not have to send a claim to us. Network providers submit claims to BCBS for you, and they are paid directly by BCBS.

### **Out-of-Network but Participating Providers**

Although many providers are a part of the BCBS PPO network, you have the freedom to visit an out-of-network provider and still receive coverage for covered services. Providers who are not part of the PPO network are called out-of-network providers.

When using an out-of-network provider, try to use a BCBS participating provider. Out-of-network but participating providers have signed agreements with BCBS to accept the BCBS approved amount as payment in full for covered services. However, because these providers are not a part of the PPO network, you must pay any required copayments and a higher deductible and coinsurance for your care.

When you go to out-of-network but participating providers, you usually don't have to submit claims. These providers, like network providers, submit claims to BCBS for you and the providers are paid directly by BCBS.

## Nonparticipating Providers

Nonparticipating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services.

If your present providers do not participate with BCBS, ask if they will accept the amount we approve as payment in full for the services you need. This is called participating on a "per claim" basis and means that the providers will accept the approved amount as payment in full for the specific services. You are responsible for any deductibles, copayments, and coinsurances required by your plan along with charges for non-covered services.

You are usually required to pay nonparticipating providers directly and then you will submit the claim to BCBS for reimbursement. Remember, the amount BCBS reimburses you may be less than the amount your provider charged. You are responsible for the amount the provider charged above the BCBS approved amount.

### Charges to You

If you receive services from a nonparticipating provider, you may have to pay the difference between the BCBS approved amount and what the provider charges.

## Change of Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with the BCBS PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network.

If you wish, you may continue your medical care with a physician that is no longer with the PPO network; however, you may be responsible for the difference between the BCBS approved amount and the provider's charges, in addition to any deductible, coinsurance and copayment required by your plan.

You can find physicians and hospitals in your area by calling the network provider locator or by visiting the Web site listed on the inside front cover of this handbook. You do not have to notify BCBS when you select or change providers. To make your appointment, just call the physician's office directly.

## Emergency Services by Out-of-Network Providers

We realize when an emergency situation occurs, you need to seek care from the nearest provider — who may not always be a network provider. If you receive treatment from an out-of-network provider for a medical emergency or accidental injury, your services will be paid at the in-network benefit level. **The treatment must be for a true emergency as determined by BCBS.** See the "Your Health Care Benefits" section of this handbook to find out what qualifies as a medical emergency.

## Referral to Out-of-Network Providers

There may be times when your network physician will refer you to another physician, such as a specialist. Usually, your physician will refer you to a physician that is part of the PPO network. If you are referred to an out-of-network physician, please contact your BCBS customer service representative to verify your referral process before receiving services. Covered medical services received from a referred physician may be subject to extra out-of-pocket costs.

## Coverage When You Travel

When you travel across the country or around the world, your health care benefits go with you. The BlueCard® program gives you access to doctors and hospitals everywhere you travel.

### Travel Across the United States

Our extensive provider network makes it easy to find participating doctors and hospitals when you travel away from home. Out-of-state participating providers will bill their local Blue plan for any covered services you receive. This means faster payment to the provider and less out-of-pocket costs for you. Here's how it works:

- **Participating providers** — Present your BCBS ID card to out-of-state participating providers. They will bill their local Blues plan for payment. Your provider also will accept the approved amount or negotiated rate (see “Glossary of Health Care Terms”) as payment in full. You are responsible for any member out-of-pocket costs (deductible, coinsurance and copayments) as identified in this handbook. Remember, your out-of-pocket costs are usually calculated on the lower of the provider's actual charge or the BCBS negotiated rate.

**Note:** If a participating provider bills you for charges other than what is required by your plan, remind the provider that he or she should accept the BCBS payment as payment in full.

- **Nonparticipating provider** — If your out-of-state provider does not participate with the local Blues plan, ask if the provider can send the bill directly to us. If not, you will need to get an itemized receipt and send it to us for reimbursement. See the “Filing Claims” section of this handbook for instructions on how to submit a claim.

### Travel Outside of the United States

When you travel outside of the United States, you still have access to your benefit as long as services are provided by a licensed physician or an accredited hospital.

Most hospitals and doctors in foreign countries will ask you to pay the bill upfront. Try to get itemized receipts, preferably written in English.

When you submit your claim, please indicate if the charges are in U.S. or foreign currency. Be sure to also indicate whether payment should go to you or to the provider. BCBS will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, less any deductible, coinsurance and copayment that may apply.

## **BlueCard®**

All BCBS licensees participate in this program. Whenever members access health care services outside the geographic area BCBSM serves, the claim for those services may be processed through BlueCard and presented to BCBSM for payment. Under BlueCard, when members receive covered health care services within the geographic area served by another BCBS plan ("host plan"), BCBSM will remain responsible to the group for fulfilling BCBSM's contract obligations. However, the host plan will only be responsible, in accordance with applicable BlueCard policies, for providing services such as contracting and other interaction with its participating providers. The financial terms of BlueCard are described generally below.

### **Liability Calculation Method Per Claim**

The calculation of a member's liability on claims for covered health care services incurred outside the geographic area BCBSM serves and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price BCBSM pays the host plan.

The calculation of the group's liability on these BlueCard claims will be based on the negotiated price BCBSM pays the host plan.

The methods employed by a host plan to determine a negotiated price will vary among plans based on the terms of each plan's provider contracts. The negotiated price paid to a host plan by BCBSM on a claim for health care services processed through BlueCard may represent:

- (i) The actual price paid on the claim by the host plan to the health care provider ("actual price")
- (ii) An estimated price, determined by the host plan in accordance with BlueCard policies, based on the actual price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the host plan's health care providers or one or more particular providers ("estimated price")
- (iii) An average price, determined by the host plan in accordance with BlueCard policies, based on a billed charges discount representing the host plan's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("average price"). An average price may result in greater variation to the member and the group from the actual price than would an estimated price.

Host plans using either the estimated price or average price will, in accordance with BlueCard policies, prospectively increase or reduce the price to correct for over- or underestimation of past prices. However, the amount paid by the member and the group is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of estimated price or average price may result in some portion of the amount paid by the group being held in a variance account by the host plan, pending settlement with its participating providers. Because all amounts paid are final, the funds held in a variance account, if any, do not

belong to the group and are eventually exhausted by provider settlements and through prospective adjustment to the negotiated prices.

Statutes in a small number of states may require a host plan either:

- (1) Use a basis for calculating a member's liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim
- (2) Add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the host plan would then calculate a member's liability and the group's liability for any covered health care services consistent with the applicable state statute in effect at the time the member received those services.

### **Return of Overpayments**

Under BlueCard, recoveries from a host plan or from participating providers of a host plan can arise in several ways, including but not limited to anti-fraud and abuse audits, health care provider audits, credit balance audits, utilization review refunds and unsolicited refunds. In some cases, the host plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

### **BlueCard Fees and Compensation**

The group understands and agrees:

1. To pay certain fees and compensation to BCBSM which it is obligated under BlueCard to pay to the host plan, to the BCBSA or to the BlueCard vendors, unless BCBSM's contract obligations to the group require those fees and compensation to be paid only by BCBSM.
2. That fees and compensation under BlueCard may be revised from time to time without the group's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. Also, some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to the group as an additional claim liability. Other fees include, but are not limited to, those for providing an 800 telephone number and for providing PPO provider directories. If the group does not have a complete listing or wants an updated listing of these types of fees or the amount of these fees paid directly by the group, it should contact BCBSM.

## Section 4:

# Making the Most of Your Health Care Plan

This section provides general information about your total health care package. Your coverage includes the following benefits:

### Medical Coverage

Your hospital and medical-surgical benefits are provided through the Preferred Provider Organization health care plan. PPO is a cost-sharing plan that provides a wide range of benefits from inpatient hospital care to physician services. Using PPO network providers will limit your out-of-pocket costs. Please see the “Your Medical Coverage” section of this handbook for more information.

### Prescription Drug Coverage

You are responsible for a copayment for each covered prescription drug or refill. Your coverage pays the rest of the cost when you go to a network pharmacy and follow coverage guidelines described in the “Prescription Drug Coverage” section of this handbook.

### Payment of Benefits

Your coverage consists of services and supplies for which BCBS agrees to pay under the terms of your employer's coverage documents. Payable services and supplies are called “benefits” and are listed in your employer's coverage documents.

The payment amount for these benefits is called the “approved amount.” This is the BCBS maximum payment level allowed for the covered services. Deductibles, copayments, coinsurances and sanctions are deducted from the approved amount. **All references to the approved amount in this handbook refer to the approved amount as determined by BCBS.**

### Value Added Resources

In addition to quality health care coverage, your plan includes the following resources:

#### My Online Health Care Benefits

The Web site, at [bcbsm.com](http://bcbsm.com) (and register for Member Secured Services so you can access all of our online services), offers completely secure, password-protected access to the personal health benefit information you need most. You can create your own account and obtain real-time access to the following information:

- **Claims** — View your claim status, including current and previous claims for the past two years. You can also view claim payment information, claim summary and claim details.
- **Eligibility** — View the coverage you are eligible for under your contract.
- **Deductibles and Maximums** — View your out-of-pocket costs and benefit limitations.
- **Provider Lookup** — View and find participating doctors and hospitals in the BCBS network, no matter where you live or travel.

- **ID Cards** — Request a replacement ID card to be sent to your home.
- **Downloads** — View, print or download forms and documents related to your health care coverage.
- **Coordination of Benefits** —Update additional health care coverage for each member on your contract.
- **Online Explanation of Benefits** —View what services have been paid by BCBS and what, if anything, you owe.

You may also access the following resources via **bcbasm.com (and register for Member Secured Services so you can access all of our online services)**:

### **BlueHealthConnection®**

Whether you're looking for ways to improve your lifestyle or manage a chronic condition, BlueHealthConnection has the support system you need – and it starts with a phone call to BlueHealthConnection at **800-775-BLUE (2583)**.

### **Working together**

Good health depends on certain life-style choices we make including what we eat, how active we are, whether or not we smoke and how we manage a chronic illness such as diabetes or high blood pressure. This is where BlueHealthConnection and our nurse coaches make a *healthcaring* difference.

When you call BlueHealthConnection, a nurse coach will work with you so that you can decide which level of care you need, including:

- **General health education** on issues such as smoking cessation and avoidance of the flu and access to our audio health library and self-help materials
- **Symptom management** and health coaching if you need general advice about medical concerns, and assistance in determining whether and where to obtain care for acute health care problems
- ***Quit the Nic***, a smoking cessation program in which you work one-on-one with a BlueHealthConnection nurse coach to develop an action plan, set a quit date and stay smoke-free for life
- **Shared decision-making** including discussion of options with a nurse coach or condition specific treatment option videos if you are considering surgery for a significant medical condition
- **Disease management** including education and coaching in self-management of chronic illnesses
- **Case management** when you have a medical condition that needs coordination of care
- **Complex case management** for patients who are extremely ill or have terminal conditions

### **Online health resources**

BlueHealthConnection also offers members a private, easy-to-use online resource for personal health and wellness information. The site has a wealth of information on health-related topics, issues and information – all custom tailored to meet your individual health needs from Michigan’s most trusted name in health care.

Once you log in to *Member Secured Services*, you can access BlueHealthConnection by clicking on the **Go** button located in the *BlueHealthConnection* section. Here’s what BlueHealthConnection online offers you:

**Health Risk Assessments** – This questionnaire, developed by doctors and leading health researchers, takes about 20 minutes to complete and gives you a clear picture of your overall health status and pinpoints your specific health issues and risks. You can even repeat the risk appraisal at different intervals to measure your changes in health.

**Personalized dashboard** – You can create your own personalized home page called a Health Dashboard that shows you how you can make health changes and suggest ways to reduce risks through education and lifestyle changes.

**Personal health record** – This tool keeps track of your important health information, including conditions, medications, doctor’s appointments, emergency information and more.

**Health information** - Offers you a wealth of information on fitness, vitamins and supplements, healthy weight, nutrition, safety and injury prevention.

**Interactive tools** – From health articles to calculator tools BlueHealthConnection’s interactive tools help you participate with your physician in planning your health goals.

BlueHealthConnection also has tools that can help you learn about general health information and how such factors as body mass affects you and your family’s health. Here are some of the interactive tools you can access online:

- Body mass index calculator
- Target heart rate calculator
- Calories burned calculator
- Children’s growth calculator
- Calcium calculator
- Heart Attack risk calculator

## **Healthcare Advisor™**

The Healthcare Advisor is an easy-to-use Web resource to help you make more informed health care decisions. It helps you navigate the health care system in a completely secure, password protected Web environment. With Healthcare Advisor you can:

- **Browse over 130 health topics** that are important to you. Use the Decision Guide, an interactive decision-making tool that can help you get the information and guidance you need for you and your loved ones.
- **Find and compare hospitals** to locate the one that’s right for you. You can search for hospitals by location, experience with the type of treatment you need, complication and infection rates and patient volumes. There’s also a link to the BCBS Web site to make sure the hospital you choose participates with the Blues.
- **Select a doctor** using the criteria most important to you. Whether it’s hospital affiliation, years of experience, gender, location or specialty, you can view information about the doctors of your choice. This resource provides a link to the BCBS Web site to make sure the doctor you choose participate with the Blues.
- **Research clinical and cost information about drugs.** You can compare drug treatment options for your condition, get information about a specific drug, check for possible drug interaction and much more.
- **Examine the treatment cost of common health care services.** This resource allows you to estimate in- and out-of-network costs as well as the overall cost of treatment for chronic conditions such as asthma or diabetes
- **Use the Tools and resources** to help you discuss your condition with your health care provider or insurance company

You also have access to the **CoverageAdvisor™**. This resource gives you information about common health care plan offerings and helps you consider the health care services you and your family are likely to need. It also estimates the costs for those services and forecasts out-of-pocket costs under various scenarios.

## **Naturally Blue<sup>SM</sup>**

For members interested in alternative approaches to better health, we created the Naturally Blue program. **Naturally Blue provides discounts on select services and natural health care products.** The Naturally Blue Program partners with Healthways, which is considered one of the nation’s largest and most experienced provider of specialized health and health care support.

When they visit a Naturally Blue participating practitioner, Michigan Blues members can get discounts off the cost of services listed below. The discount amount is listed in the “Find a Practitioner” search feature at **bcbsm.wholehealthmd.com**.

- Acupuncture
- Exercise/movement advisors
- Diet and supplement
- Massage and bodywork
- Mind/body relaxation techniques
- Wellness/fitness centers
- Reference library

## **How to Receive a Discount**

**Show your Michigan Blues member ID card to the network practitioner** when you arrive for each visit. There is no limit to the number of times you can receive discounted services.

## Section 5: Your Health Care Benefits

This section of your handbook explains the benefits provided by your PPO health care plan. These benefits include coverage for your hospital care and the services you receive from a physician. **Unless otherwise indicated, all benefits in this section are subject to your coverage’s deductible, copayments, coinsurance and benefit maximums.**

### Medical Necessity

A service that you receive from a medical provider must be medically necessary, or a specified preventive service, in order to be payable under your health care plan. The guidelines for determining medical necessity are specified in detail in the “Glossary of Health Care Terms” section of this handbook.

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

- When you do not inform the hospital that you are a BCBS member either at the time of admission or within 30 days after you are discharged
- When you fail to provide the hospital with information that identifies your coverage

### Your Out-of-Pocket Costs

For most covered services, you are required to pay a portion of the approved amount through deductibles, copayments and coinsurances. See the following chart for your out-of-pocket cost requirements and BCBSM payment percentages for covered services.

Description	In-Network	Out-of-Network
<b>Benefit Period</b>		
A benefit period is based on a calendar year beginning Jan. 1 and ending Dec. 31. Your first benefit period may be shorter, depending on your employment date and when you become eligible for coverage.		
<b>Deductible</b>		
Deductible is a specified amount that you are required to pay for covered services during each benefit period before benefits are paid by your plan.		
<b>Individual</b>	\$750	\$1,000
<b>Family</b>	\$1,500	\$2,000
When one individual has met the deductible benefits are payable for covered services <b>for that individual</b> . Services for the remaining family members will be paid when the full family deductible is met. Only the approved amount you pay for services covered under this plan can be used to meet your deductible.		

Description	In-Network	Out-of-Network
<b>Copayment</b>		
Copayment is a flat dollar amount you must pay for eligible services. When a copayment is charged for a service, it may also be subject to an additional coinsurance.		
<b>Copayment</b>	\$20 copayment for: <ul style="list-style-type: none"> <li>• Home and office visits by Primary Care Physician (PCP)</li> <li>• Medical care for accidental injury and medical emergency in an office setting</li> <li>• Initial prenatal visit to determine pregnancy</li> <li>• Routine physical exam</li> <li>• Routine gynecological exam</li> <li>• Well child care</li> <li>• Outpatient mental health services</li> <li>• Outpatient substance abuse treatment</li> </ul>	

Description	In-Network	Out-of-Network
<b>Copayment (continued)</b>		
<b>Copayment</b>	\$40 copayment for: <ul style="list-style-type: none"> <li>• Home and office visits by Specialist</li> <li>• Consultations</li> <li>• Chiropractic services</li> <li>• Allergy injections (therapy)</li> <li>• Physical, occupational and speech therapy</li> </ul> \$75 copayment for: <ul style="list-style-type: none"> <li>• Urgent care services</li> </ul> \$200 copayment for: <ul style="list-style-type: none"> <li>• Emergency room visit (waived if admitted)</li> </ul>	\$200 copayment for: <ul style="list-style-type: none"> <li>• Emergency room visit (waived if admitted)</li> </ul>
<b>Coinsurance</b>		
Coinsurance is the percentage of the approved amount you must pay for eligible services once you have met your deductible requirements.		
<b>Coinsurance</b>	You pay 20% unless otherwise noted	You pay 40% unless otherwise noted

<b>Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Preventive Services</b>		
Routine physical exam – once per benefit period, beginning at age 16	Covered 100% after \$20 copayment	Not covered
Routine gynecological exam – once per benefit period	Covered 100% after \$20 copayment	Not covered
Well child care – <ul style="list-style-type: none"> <li>• 6 visits per year through age 1</li> <li>• 2 visits per year, ages 2 through 3</li> <li>• 1 visit per year, ages 4 through 15</li> </ul>	Covered 100% after \$20 copayment	Not covered
Immunizations (child and adult)	Covered 100%	Not covered
Pap smear screening (laboratory services only) –  once per benefit period	Covered 100%	Not covered
Routine mammogram – once per benefit period, no age restrictions	Covered 100%	Not covered
Prostate specific antigen (PSA) screening – Once per benefit period, no age restrictions	Covered 100%	Not covered
Laboratory services, diagnostic tests and X- rays related to a routine exam	Covered 100%	Not covered
Routine Endoscopic Procedures – once per benefit period	Covered 100%	Not covered
<b>Physician Office Services</b>		
Office visits	Covered 100% after \$20 (PCP) copayment/ \$40 (specialist) copayment	Covered 60% after deductible
Clinic visits	Covered 100% after \$20 copayment	Covered 60% after deductible
Urgent care visits	Covered 100% after \$75 copayment	Covered 60% after deductible

<b>Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Emergency Medical Care</b>		
Qualified medical emergency and accidental injury (hospital emergency room)	Covered \$200 copayment, then 80% after deductible (copayment waived if admitted)	Covered \$200 copayment, then 80% after deductible (copayment waived if admitted)
Medical care for medical emergency and accidental injury in an office setting	Covered 100% after \$20 copayment	Covered 60% after deductible
Non-emergency use of the emergency room	Not covered	Not covered
Ambulance services (ground and air medically necessary transport)	Covered 80% after deductible	Covered 80% after deductible
<b>Diagnostic Services</b>		
Outpatient diagnostic services (MRI, MRA, PET, CAT Scans, Nuclear Medicine)	Covered 80% after deductible	Covered 60% after deductible
Laboratory, pathology and diagnostic tests and X-rays	Covered 100%	Covered 60% after deductible
Radiation therapy	Covered 80% after deductible	Covered 60% after deductible
<b>Maternity Services Provided by a Physician</b>		
Initial prenatal visit to determine pregnancy	Covered 100% after \$20 copayment	Covered 60% after deductible
Prenatal and postnatal care	Covered 100%	Covered 60% after deductible
Delivery and nursery care	Covered 80% after deductible	Covered 60% after deductible
<b>Hospital Care</b>		
Inpatient hospital care (general nursing care, intensive care units, drugs, equipment and supplies, room and board, etc.)	Covered 80% after deductible	Covered 60% after deductible
	Unlimited days	
Inpatient consultations	Covered 80% after deductible	Covered 60% after deductible
Chemotherapy	Covered 80% after deductible	Covered 60% after deductible

Description	In-Network	Out-of-Network
<b>Alternatives to Hospital Care</b>		
Skilled nursing care	Covered 80% after deductible	Covered 60% after deductible
	Limited to 60 days per member, per benefit period	
Hospice care	Covered 80% after deductible	Covered 60% after deductible
	Limited to a lifetime maximum of 360 days per member	
Home health care	Covered 80% after deductible	Covered 60% after deductible
	Limited to 60 visits per member, per benefit period	
<b>Surgical Services</b>		
Surgery (includes related surgical services)	Covered 80% after deductible	Covered 60% after deductible
Presurgical consultation	Covered 100% after \$40 copayment	Covered 60% after deductible
Voluntary sterilization (reversal procedures are not covered)	Covered 80% after deductible	Covered 60% after deductible
<b>Human Organ Transplants</b>		
Specified organ transplants ( <b>Covered –in designated facilities only</b> when coordinated through the BCBSM Human Organ Transplant Program. Call HOTP at 800-242-3504.)	Covered 100%	Not covered
	Included in general lifetime maximum	
Bone marrow (Covered when coordinated through the BCBSM Human Organ Transplant Program; specific criteria applies. Call HOTP at 800-242-3504)	Covered 80% after deductible	Covered 60% after deductible
Kidney, cornea and skin	Covered 80% after deductible	Covered 60% after deductible

<b>Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Mental Health Care and Substance Abuse Treatment</b>		
Inpatient mental health care	Covered 80% after deductible	Covered 60% after deductible
	Unlimited	
Outpatient mental health care	Covered 100% after \$20 copayment	Covered 60% after deductible
	Unlimited	
Inpatient substance abuse treatment	Covered 80% after deductible	Covered 60% after deductible
	Unlimited	
Outpatient substance abuse treatment	Covered 100% after \$20 copayment	Covered 60% after deductible
	Unlimited	
<b>Other Services</b>		
Cardiac rehabilitation	Covered 80% after deductible	Covered 60% after deductible
Allergy injections (therapy)	Covered 100% after \$40 copayment	Covered 60% after deductible
Allergy testing	Covered 80% after deductible	Covered 60% after deductible
Chiropractic services	Covered 100% after \$40 copayment	Covered 60% after deductible
	Limited to 60 visits per member, per benefit period	
Outpatient physical, speech and occupational therapy	Covered 100% after \$40 copayment	Covered 60% after deductible
	Limited to 60 visits combined per member, per benefit period	

Description	In-Network	Out-of-Network
<b>Other Services (continued)</b>		
Durable medical equipment and medical supplies	Covered 80% after deductible	Covered 60% after deductible
	Maximum of \$2,500 per calendar year	
Diabetic supplies (test strips and lancets)	Covered 80% after deductible	Covered 60% after deductible
Contraceptive devices (physician-prescribed contraceptive devices such as diaphragms and IUDs)	Covered 80% after deductible	Covered 60% after deductible
Prosthetic and orthotic appliances	Covered 80% after deductible	Covered 60% after deductible
	Maximum of \$2,500 per calendar year	
Wigs (Chemo diagnosis only)	Covered 80% after deductible	Covered 60% after deductible
	Maximum of \$250 per calendar year	
Private duty nursing	Covered 80% after deductible	Covered 60% after deductible
<b>Out-of-Pocket Maximum</b>		
Out-of-pocket maximum limits the amount you will be responsible for paying each year for services received. Once your individual and family expenses reach a certain amount, most services will be paid at 100 percent.		
Individual	\$3,500	\$8,000
Family	\$7,000	\$16,000
<p>The following amounts or charges may <b>not</b> be used to meet your out-of-pocket maximum:</p> <ul style="list-style-type: none"> <li>• Deductible amounts</li> <li>• Fixed dollar copayments</li> <li>• Charges that exceed the approved amount</li> <li>• Charges for non-covered services</li> <li>• Deductibles or coinsurance required under other BCBS coverage</li> </ul>		
<b>Lifetime Maximum</b>		
Your coverage is limited to a general lifetime dollar maximum of \$1 million per member for covered services.		

**All benefits described below are subject to any deductibles, copayments, coinsurances or benefit maximums detailed earlier in this section.**

## **Hospital Benefits — Inpatient Care**

For an approved hospital admission, your plan will cover the following inpatient hospital services. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed earlier in this section.

If you choose to receive services from a nonparticipating hospital or facility, your coverage pays 60 percent of the approved hospital or facility charge, less your coinsurance and deductible.

### **Precertification of Hospital Admissions**

Precertification is required for all inpatient hospital admissions. A precertification review determines if a hospital admission or service is appropriate. This process eliminates unnecessary inpatient hospital care and determines an appropriate length of stay for an admission. Approval of an admission does not guarantee payment. Please make sure that you and your provider confirm your coverage limitations or exclusions.

### **Room and Board**

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

### **General Medical Care Days**

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

- **Maternity and nursery care** — Coverage for obstetrical and maternity care includes delivery room costs and ordinary nursery care for a newborn during the mother's hospital stay. After the hospital stay, the newborn is covered as a dependent child, but **only if you add the child to your coverage within 30 days of birth**. Your benefits include coverage for medically necessary termination of pregnancy. Maternity services **are not** covered for a normal pregnancy and delivery for dependent children.
- **Cosmetic surgery** — Admissions for cosmetic and reconstructive surgery are covered for the correction of birth defects, conditions resulting from accidental injuries or traumatic scars and the correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.
- **Dental surgery** — Admissions for dental surgery are covered for the removal of impacted teeth or multiple extractions **only** when a concurrent hazardous medical condition, such as a heart condition, exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

## **Mental Health Care and Substance Abuse Treatment Days**

You have coverage for inpatient mental health care and inpatient substance abuse treatment in a BCBS-approved hospital. Benefits also are available when services are provided in BCBS-approved day- and night-care centers.

Care provided during a mental health or substance abuse treatment admission can include individual and group therapy sessions and family counseling when provided through an approved facility.

Fully licensed psychologists with hospital privileges can be directly reimbursed for the following inpatient services:

- Psychological testing
- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Inpatient consultations when your physician requires assistance of a consulting psychologist in diagnosing or treating your mental health condition

**Important:** Inpatient mental health care and substance abuse treatment admissions are covered only if they meet BCBS severity of illness and intensity of service criteria. If you are not sure that the criteria will be met, please have your physician call the Blue Cross Blue Shield Mental Health Precertification Unit.

## **Hospital Services and Supplies**

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

- **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service.
- **Blood services** — Includes blood derivatives, whole blood, blood plasma and supplies used for administering the services beginning with the first pint of blood
- **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service
- **Drugs** — Includes medicines prescribed and given during a hospital admission
- **Durable medical equipment** — Includes items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay
- **Medical and surgical supplies** — Includes gauze, cotton and solutions used during the hospital admission
- **Prosthetic and orthotic appliances** — Includes items that are surgically implanted in the body, such as heart valves
- **Special care units** — Includes operating, delivery and recovery rooms

Your coverage includes the following diagnostic and radiology services:

- **CAT and MRI scans** — Covers scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBS
- **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury
- **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy
- **Diagnostic radiology** — Includes ultrasound and X-rays required for the diagnosis of an illness or injury

## Hospital Benefits — Outpatient Care

The following services are covered when performed in the outpatient department of a participating hospital or, where noted, in a freestanding facility approved by BCBS. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed earlier in this section.

### Emergency Room Care

You are covered for the treatment of accidental injuries or conditions that BCBS determines are medical emergencies.

- An **accidental injury** is physical damage caused by an action, object, or substance from outside of the body. This includes strains, sprains, fractures, cuts and bruises; allergic reactions, frostbite, sunburn and sunstroke; swallowing poisons and medication overdosing; and inhaling smoke, carbon monoxide or fumes.
- A **medical emergency** is a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

### Preadmission Testing

Preadmission testing is covered when performed in the outpatient department of a hospital within seven days of a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.

### Physical, Occupational and Speech Therapy

Your physical, occupational and speech therapy services are payable when provided in:

- The outpatient department of participating hospitals
- Participating outpatient therapy facilities

In addition, therapy services are payable in physicians' offices and offices of independent, licensed therapists.

**Important:** Payment for therapy is based on the diagnosis and the location. Ask your physician or therapist to call Blue Cross Blue Shield to verify if the treatment meets diagnosis requirements, and if the prescribed therapy will be rendered in a payable location before receiving therapy treatment.

Therapy must:

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

Examples of covered therapy are:

- Physical therapy prescribed to restore the musculoskeletal functioning of legs
- Physical therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints
- Speech and language pathology services to treat severe congenital or developmental disorders. These disorders must meet objective guidelines for the assessment of severity (see Speech Pathology Severity Guidelines in glossary), or generally accepted standards of practice. Additionally, treatment plans for these conditions must contain measurable treatment goals that providers regularly assess. Progress toward goals must be documented in the clinical record in order for coverage to continue.

Your coverage does not pay for:

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

## **Cardiac Rehabilitation**

You have coverage for cardiac rehabilitation services. This benefit is payable if it is provided:

- In a hospital-based or freestanding (not owned or operated by a hospital) cardiac rehabilitation center
- By a licensed physician (M.D. or D.O.) or professionals working under the direct supervision of a licensed physician
- Within six months of a diagnosis of acute myocardial infarction, angina pectoris or a prior related professional cardiac service, including coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation or heart valve surgery
- For physician prescribed exercises to cardiac patients during phases II and III of their cardiac rehabilitation treatment

- Within the 12 week total time allowed for cardiac rehabilitation

Phase II services include:

- Six-week program that follows inpatient admission or outpatient services for a heart condition
- Complete medical history
- Stress test with electrocardiogram monitoring
- Lipid profile
- ECG
- Three exercise sessions per week
- Nutrition and risk factor recognition classes

**Note:** Patient education services and ECG testing are not covered as a separately identifiable service when reported as part of cardiac rehabilitation.

### **Outpatient Mental Health Care**

Your coverage includes psychological testing, individual and group therapy sessions and family counseling when provided through an approved facility, by a physician or by a fully licensed psychologist.

### **Outpatient Substance Abuse Treatment**

Your coverage includes outpatient substance abuse treatment provided at an approved substance abuse treatment facility. These benefits are payable up to the annual minimum dollar amount designated by state law. Since this amount is adjusted annually, call a BCBS customer service representative for the current benefit amount.

### **Additional Hospital Services and Programs**

Your coverage will pay the approved amount for the following services provided by a participating hospital or an approved facility, as indicated below. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed earlier in this section.

#### **Chemotherapy**

You may receive chemotherapy treatment in a hospital, in the outpatient department of a hospital or in a physician's office.

Benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy and provided as part of a chemotherapy program, if the treatment is not considered experimental or investigative.

#### **Hemodialysis**

Hemodialysis services to treat acute renal (kidney) failure and end stage renal disease are a benefit. Treatment may take place in the outpatient department of a hospital, in a licensed facility or in the home. Home hemodialysis must be arranged by a physician and services must be billed by a participating hospital that has an approved hemodialysis program. Coverage includes the cost of the equipment, installation, training and necessary hemodialysis supplies.

**Note:** Dialysis services for the treatment of ESRD are coordinated with Medicare. It is important for individuals with ESRD to apply for Medicare coverage regardless of age. BCBS is the primary payer for up to 30 months if the member is under 65 and is eligible for Medicare solely because of ESRD.

## **Home Hemophilia Program**

The Home Hemophilia Program provides benefits for the necessary medications and supplies used to treat hemophilia in a home setting. All medications and supplies needed for the patient to *self-infuse* at home, including syringes, needles and the antihemophilic factor, must be supplied by a participating hospital. Benefits may also include training to the patient or a family member on how to inject the antihemophilic factor, when the training is provided through a participating hospital. Services are coordinated through the Individual Case Management Program.

## **Home Health Care**

Your benefits include home health care visits when the patient is referred to and accepted by a participating home health care agency. The services must be prescribed by a physician who submits a detailed treatment plan to the home health care agency and certifies that home health care is medically necessary.

Home health care benefits include nursing services; physical, occupational or speech therapy; social service and nutritional guidance, medication, supplies and lab work.

## **Skilled Nursing Care**

A convalescent care facility provides skilled, comprehensive inpatient care for either a short or extended period of time. Your coverage includes skilled nursing care in an approved skilled nursing facility, when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve.

Convalescent care benefits cannot be used for custodial care or care for mental deficiency, mental retardation, senile deterioration or cases in which the prognosis is unfavorable.

## Human Organ Transplants

The following types of human organ transplants are covered when received at a participating hospital or, where noted, in a BCBS-approved transplant facility. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed earlier in this section.

## Organ and Tissue Transplants

Benefits are payable for services and expenses for transplanting organs and tissues to an eligible recipient when performed in a participating facility. Coverage includes evaluation and surgical removal of the donated organ (including skin, cornea and kidney) from a living or non-living donor. These transplants are subject to the same guidelines as other PPO benefits.

## Bone Marrow Transplants

Benefits for **allogeneic** bone marrow transplants are payable only when the bone marrow, peripheral blood stem cells or umbilical cord blood of another person is transplanted into the patient to treat the following conditions and is not considered experimental or investigational:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Aplastic anemia
- Beta thalassemia major
- Chronic myeloid leukemia
- Hodgkin's disease (relapsed and stage III or IV)
- Hurler's syndrome
- Myelodysplastic syndromes
- Myelofibrosis
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Sickle cell disease (when complicated by stroke)
- Wiskott-Aldrich syndrome
- X-linked lymphoproliferative syndrome

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

**Note:** Human leukocyte antigen genetic markers are specific chemical groupings of many body cells, including white blood cells used to detect the constitutional similarity of one person to another.

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

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Ewing's sarcoma
- Germ cell tumors of ovary, testis, mediastinum and retroperitoneum
- Hodgkin's disease (stage III or IV)
- Medulloblastoma
- Metastatic breast cancer (stage IV)
- Multiple myeloma
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Primitive neuroectodermal tumors
- Rhabdomyosarcoma
- Wilms' tumor

Payable benefits for bone marrow transplants include:

- High dose chemotherapy and total body radiation
- Blood tests on immediate relatives for evaluation as donors if the tests are not covered by the donor's plan
- Harvesting the marrow and peripheral blood stem cells if the donor meets specific genetic marker requirements for **allogeneic** bone marrow transplants; harvesting and storing the marrow and peripheral blood stem cells for a transplant intended to be performed within one year for **autologous** bone marrow transplants
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established.
- Infusion of colony simulating growth factors
- Hospitalization
- Services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting as indicated above)

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

Your coverage does not pay for:

- Any services related to or for allogeneic bone marrow transplants or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements
- Purging of or positive stem cell selection of bone marrow stem cells or peripheral blood stem cells
- Harvesting and storage costs of bone marrow or peripheral blood stem cells if not intended for transplant within one year
- Health care services provided by people who are not legally qualified or licensed to provide such services
- Services that are not medically necessary (see the “Glossary of Health Care Terms” section for definition of medically necessary)
- Any facility, physician or associated services related to any of the above exclusions
- Services that are experimental or investigational
- Services rendered to a donor when the donor’s health care coverage will pay for such services

## **Specified Human Organ Transplants**

Hospital care for specified human organ transplants performed during the transplant benefit period is covered in full when the transplant is preapproved by Blue Cross Blue Shield and received at a Blue Cross Blue Shield designated transplant facility.

- Benefits apply only to transplants of the:
  - Liver
  - Partial liver (a portion of the liver taken from a cadaver or living donor)
  - Heart
  - Lung(s)
  - Lobar lung (transplantation of a portion of a lung from a cadaver or living donor)
  - Heart-lung(s)
  - Pancreas
  - Simultaneous pancreas-kidney

- Small intestine (small bowel)
- Combined small intestine-liver
- All payable human organ transplant services, except anti-rejection drugs and other transplant related prescriptions, must be provided during the benefit period that begins five days before the transplant surgery and ends one year after the surgery.
- Providers must submit a request to BCBS for preauthorization for all specified organ transplants before a transplant is performed. Authorization for the transplant surgery will be sent to the patient and the transplant facility or the patient's physician (whoever requests the preauthorization).

**Note:** Call a BCBS customer service representative to confirm a facility's participation status.

When directly related to the transplant we will pay for the following services. Benefits are limited to a lifetime maximum for each type of specified human organ transplant. This maximum is included the general lifetime maximum.

- Facility and professional services.
- Anti-rejection drugs and other transplant-related prescription drugs, as needed. Payment will be based on the amount we determine to be reasonable and necessary.
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs **during** the benefit period, and is a **direct** result of the organ transplant surgery. We will pay for any medically necessary service needed to treat a condition as a **direct** result of the organ transplant surgery, if it is a benefit under any of our certificates.
- Up to \$10,000 for travel, meals and lodging directly related to preapproved services. We will pay the cost of transportation to and from the designated transplant facility for an adult patient and one companion eligible to accompany the patient (or two companions if the patient is younger than 18 or if the transplant involves a living related donor). As part the \$10,000 we will pay the reasonable and necessary costs of lodging for the companion(s) eligible to accompany the patient, and meals for the patient and companion(s) eligible to accompany the patient up to a combined maximum of \$40 per day.
- The cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ and payment for covered services for a donor if the donor does not have transplant services under any health care plan. The total payment for all services combined for each organ transplant will not be more than the general lifetime maximum.

Benefits are not payable for:

- Non-covered services
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval

- Transplant surgery and related services the patient receives in a nondesignated facility
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and hospitalization
- Any expenses incurred for transportation, meals and lodging after the initial transplant surgery and hospitalization
- Items **not** considered directly related to travel, meals, and lodging expenses. They include, **but are not limited to**, dry cleaning, clothing, laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers, cards, stationary, stamps, household products, household utilities including cell phone charges, maid services, baby-sitter, day-care services.
- Services prior to the patient's transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage
- Experimental transplant procedures

### **Waiting Period**

Specified human organ transplants needed as the result of a pre-existing condition are not payable during the pre-existing condition exclusion period applicable to your coverage.

## **Physician Benefits**

You have coverage for the physician services described below.

### **Office Visits**

Your benefits include visits to a physician's office, outpatient clinic or outpatient department of a hospital for the examination, diagnosis and treatment of general medical conditions. Services include medical care, consultations, medication and injections.

### **Preventive Services**

You have coverage for the following preventive services.

- **Routine physical exam** — You have coverage for one routine physical per member, per benefit period, beginning at the age of 16.
- **Routine gynecological exam** — You have coverage for one routine gynecological exam per benefit period for female members.
- **Well child care** — Your benefits include visits to a physician to monitor the development of a child up to and including the age of 15. Benefits are subject to the following frequency limitations:
  - 6 visits per year for children up to and including age 1
  - 2 visits per year for children up to and including ages 2 through 3
  - 1 visit per year for children up to and including ages 4 through 15

- **Laboratory and screening services** — You have coverage for routine laboratory, diagnostic tests and X-rays related to a routine exam which include but are not limited to:
  - Chemical profile
  - Complete blood count (CBC)
  - Fecal occult blood screening
  - Urinalysis
  - Chest X-ray
  - EKG
  - Endoscopic procedures (proctosigmoidoscopy, sigmoidoscopy, colonoscopy, etc.)
- **Routine mammograms** — You have coverage for one routine mammogram (breast X-ray) for female members per benefit period. More frequent mammograms are covered as diagnostic services if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.
- **Pap smear** — You have coverage for laboratory services for one routine pap smear, per benefit period for female members. More frequent pap smears are covered as diagnostic services for the following conditions:
  - Previous surgery for vaginal, cervical or uterine malignancy
  - Presence of a suspected lesion in the vaginal, cervical or uterine areas
  - Post-surgery
- **Prostate specific antigen screening** — Your coverage includes one PSA screening laboratory test for male members per benefit period.
- **Immunizations** — Your coverage also includes the following:
 

**Pediatric** immunizations, which are currently recommended by the United States Center for Disease Control and Prevention, Advisory Committee on Immunizations Practices, American Academy of Pediatrics, and the American Academy of Family Physicians.

**Adult** immunizations, including all of the recommended childhood immunizations and all adult immunizations recommended by the CDC and the ACIP.

## Allergy Services

Allergy testing and therapy are covered when performed by or under the supervision of a physician. Services include scratch and puncture testing, allergy survey, allergy serum and therapeutic injections.

## Chiropractic Services

Your benefits include the following chiropractic services:

- **New patient office calls** — Covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.

- **Office visits** — Covers one per benefit period for established patients
- **Chiropractic Traction** — Number of payable visits is determined by your physical therapy benefit.
- **Chiropractic Manipulation** — Up to 60 medically necessary visits per benefit period.

## Maternity Care

You have coverage for obstetrical services including delivery and pre- and postnatal care visits. The initial inpatient examination of the newborn also is covered when performed by a physician other than the delivering provider. Your benefits include coverage for medically necessary termination of pregnancy. Maternity care **is not** covered for normal pregnancy and delivery for dependent children.

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

Group health plans and health insurance issuers generally may not, under federal law, 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 or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Physician Emergency Care

Emergency care benefits cover physician services for the initial examination and treatment of accidental injuries and conditions determined by BCBS to be medical emergencies. These terms are explained in the "Glossary of Health Care Terms" section.

## Inpatient Medical Care

While you are an inpatient, you are covered for an unlimited number of medical visits by a physician for general medical conditions that are not related to surgery or maternity care.

## Inpatient Consultations

In complicated situations, the physician in charge of the case may consult another physician for assistance or advice about diagnosis or treatment. Necessary inpatient consultations are covered when they are requested by the attending physician.

## Presurgical Consultation

A presurgical consultation can help you obtain additional information about the benefits and risks of your proposed surgery and inform you of any alternative treatments that may be available. X-rays and laboratory services your doctor may request will be covered according to the level of benefits outlined in this handbook.

The physician's recommendation does not affect the approved amount for the surgery. Whether or not the recommendation from the second physician favors surgery, **you make the final decision about the surgery.**

## **Surgery**

Surgical procedures needed for the diagnosis and treatment of diseases and injuries are covered. Surgical benefits include all related pre- and post-operative medical care by the attending surgeon.

- **Multiple surgeries** (two or more surgical procedures during one operative session) are subject to payment limitations:
  - When the surgeries are through **different** incisions, your coverage will pay the approved amount for the primary surgery (the procedure with the higher benefit payment), plus half the approved amount for any additional procedures.
  - When the surgeries are through the **same** incision, your coverage will pay the approved amount only for the primary surgery. (Physician payment for additional surgeries through the same incision is included in the amount paid for the primary surgery.)
- **Note:** Participating providers accept these approved amounts, less any required deductible, coinsurance and copayment for multiple surgeries as payment in full.
- **Laser surgery** is a benefit when the procedure is not considered experimental or investigative and the payment is not more than that allowed for conventional surgical procedures.
- **Breast reconstruction surgery is covered for:**
  - Reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas
- **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars and for correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- **Dental surgery** for the removal of impacted teeth or multiple extractions is covered only when the patient must be hospitalized for the surgery because a concurrent medical condition exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.
- **Voluntary sterilization** for both male and female patients is covered regardless of medical necessity. Reversal procedures **are not** covered.

## Ambulatory Surgery Care

Your coverage includes surgical services performed in an ambulatory surgery facility. This generally includes elective surgery that does not require the use of hospital facilities but cannot routinely be performed in an office setting.

## Technical Surgical Assistance

Surgical assistance provided by another physician when requested by the operating surgeon is covered. However, it is payable only when an intern or hospital physician is not available for assistance. The surgery requiring assistance must be an approved major surgical procedure.

## Anesthesia

Your benefits include the administration of drugs or gases when they are necessary for a covered service, and when they are given by a physician other than the operating surgeon or an assistant, or by a certified registered nurse anesthetist. Anesthesia provided by a nurse anesthetist under the supervision of an anesthesiologist also is covered.

## Diagnostic and Radiation Services

All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed earlier in this section.

- **Diagnostic radiology** — Benefits include outpatient diagnostic radiology services required for the diagnosis of an illness or injury when performed and billed by a physician. These services may be performed in the physician's office or in the outpatient department of a hospital. Covered services include ultrasound and diagnostic X-rays. MRI and CAT scans of the head and body also are covered when performed for an eligible diagnosis in approved facilities.
- **Laboratory and pathology services** — Laboratory and pathology services performed in the physician's office or in the outpatient department of a hospital and ordered and billed by a physician are covered. This benefit includes laboratory and pathology tests required in the diagnosis of an illness or injury.
- **Diagnostic tests** — Diagnostic tests performed in the physician's office or in the outpatient department of a hospital are covered when performed and billed by a physician. Covered tests include EKGs, EMGs, EEGs, thyroid function tests, and nerve conduction studies required in the diagnosis of an illness or injury.
- **Radiation therapy** — Radiation therapy performed in the physician's office or in the outpatient department of a hospital is covered when performed and billed by a physician. Covered services include radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

## Additional Benefits

Your coverage will pay the approved amount for the following additional benefits. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed earlier in this section.

## **Ambulance Services**

Ground and air ambulance services required because of an injury or hospital admission are covered. Services must be medically necessary and prescribed by the attending physician. The patient may be transported to and from the hospital, between hospitals, and between hospitals and approved medical facilities. Services must be provided by a licensed ambulance company. This benefit includes the equipment used, mileage and waiting time. Services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation are not covered.

## **Prescribed Contraceptive Devices**

Your coverage includes physician-prescribed contraceptive devices such as diaphragms and IUD or contraceptive implants designed to prevent pregnancy.

## **Durable Medical Equipment**

Benefits are covered for rental or purchase (whichever is less expensive) and repair of durable medical equipment appropriate for home use and prescribed by a physician. Examples of durable medical equipment are canes, wheelchairs and walkers.

The equipment must be medically necessary for the treatment of an illness or injury or used to improve the functioning of the patient's body. Equipment primarily for the comfort or convenience of the patient is not covered.

## **Prosthetic and Orthotic Appliances**

Benefits are provided for external appliances to replace a missing part of the body or to correct any defect of form or function of the body. Benefits include temporary appliances, delivery, services and fitting charges.

These appliances must be prescribed by a physician and supplied by a fully accredited facility approved by the American Board of Certification in Orthotics and Prosthetics.

Adjustment or replacement of eligible appliances is payable only when required because of normal wear or growth or a change in the patient's condition. Examples of these appliances are braces and artificial arms and legs.

## **Prosthetic Appliances Following Mastectomy**

Benefits are provided for an external breast prosthesis following a mastectomy when prescribed by a physician. Benefits cover two post-surgical forms and two surgical bras every benefit period. Replacements are payable only when required because of a significant change in body weight or when necessary for hygienic reasons.

## **Oxygen and Other Therapeutic Gases**

Oxygen and equipment to administer the oxygen are covered when medically necessary and prescribed by a physician.

## **Optical Services Following Cataract Surgery**

Your benefits include the examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery. Cataract sunglasses are not covered.

## **Dental Services**

Dental services and appliances required for the treatment of an accidental injury are covered. The injury must have been caused by an external force. Injuries resulting from biting or chewing are not covered.

## **Medical Supplies and Dressings**

Your coverage includes medically necessary medical supplies and dressings that are used to treat a diagnosed condition.

## **Podiatrist Services**

Your coverage includes routine foot care services.

## **Private Duty Nursing**

Private duty nursing is covered when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis. Non-skilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered.

The services must be prescribed by a physician and provided by a registered nurse or licensed practical nurse. The attending physician must complete a certification statement each month the patient is under care.

## **Pain Management**

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

## **Individual Case Management Program**

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

A case management analyst evaluates a patient for ICMP who has been referred by a hospital, physician or a family member. When the patient is accepted as a candidate for ICMP, an analyst works with the patient's family and physician to develop a personal treatment plan, called the alternative benefit plan. The plan is discussed with the patient, the family and the attending physician before the recommendations are finalized. The analyst explains all the benefits, resources, facilities and services that are part of the treatment plan. These can include services

not normally included in your coverage. The analyst also identifies all payable services and payment arrangements related to the plan.

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

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

Once the plan is implemented, participation will be canceled in either of the following situations:

- The patient's condition no longer requires the extra benefits documented in the alternative benefit plan.
- The total amount paid under the alternative benefit plan exceeds the amount that would be payable under the patient's regular facility coverage.

If you have questions about individual case management, contact your BCBS customer service representative.

## Hospice Care

A hospice is an agency or facility that is primarily involved in providing care to terminally ill individuals. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

Hospice benefits replace the benefits normally available under your medical coverage with benefits that are specific to the patient's needs. These may include alternative services to provide more appropriate care for the patient. However, services for medical conditions unrelated to the terminal illness are subject to the medical coverage guidelines.

You may apply for hospice benefits only after discussion with and referral by your attending physician. All hospice services must be arranged through an approved hospice provider.

### Levels of Care

The hospice program provides four levels of care:

- **Routine home care** — Consists of services provided to patients who are living at home and are not receiving continuous home care. See next item. Benefits include counseling, home health care and physical therapy. Such care must not exceed eight hours per day.
- **Continuous home care** — Consists of nursing care services provided to patients during crisis periods to enable them to stay in their homes. Such care must be provided for a minimum of eight continuous hours per day.
- **Inpatient respite care** — Consists of short-term inpatient services to allow home care providers short periods of relief. Such care must be provided in an approved facility on a non-routine or occasional basis and in increments of five days or less in any 30-day period.

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

## **PPO Exclusions and Limitations**

In addition to the exclusions and limitations listed elsewhere in this handbook, unless otherwise stated, the following exclusions and limitations apply:

- Care and services available at no cost to you in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
- Custodial care, rest therapy and care in nursing or rest home facilities
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition, such as a heart condition, exists
- Any medical care, hospitalization or service provided **before** the effective date of coverage or **after** the coverage termination date
- Routine hospital outpatient care requiring repeat visits for the treatment of chronic conditions such as diabetes
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), basal metabolism tests or electrocardiography. Also, gastric bypass, lap banding and testing for these procedures.
- Items for the personal comfort or convenience of the patient
- Psychiatric services after determination that the patient's condition will not respond to treatment
- Psychological tests for vocational guidance or counseling
- Routine premarital or pre-employment exams
- Prescription drugs (may be covered under an additional freestanding program)
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Services provided through a medical clinic or similar facility provided or maintained by an employer
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund
- Care and services received under another BCBS plan

- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which the member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal law requires Medicare to be secondary.
- Cosmetic surgery solely for improving appearance, except as specified in this handbook
- Treatment of a condition caused by military action or war, declared or undeclared
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made; services for which the patient is not obligated to pay
- Dialysis services after 33 months of end stage renal disease treatment
- Services that are not included in your employer's coverage documents
- Charges from a nonparticipating provider that are in excess of the BCBS approved amount
- Charges for hospital room accommodations over and above the hospital's regular charges covered by your medical benefits
- Transportation and travel except as specified in this handbook
- Hearing exam and preparation, fitting or procurement of hearing aids
- Eyeglasses or contact lenses and vision examinations for prescribing or fitting them (except for aphakic patients) or for soft contact lenses or sclera shells intended for use in the treatment of diseases or injury or as specified following cataract surgery
- Injections for cosmetic purposes
- Immunizations and vaccines required when traveling out of the country
- Charges for examinations required by school, camp, licensing or for any other regulatory purpose
- Therapy or hospital admission for weight control
- Therapy for smoking cessation
- Testing more frequently than necessary
- Dental care and dental appliances except those specified in your coverage
- Elective termination of pregnancy
- Reversal of sterilization procedures
- Experimental bone marrow transplants
- Specified oncology clinical trials
- Infertility testing and/or treatment procedures
- Artificial insemination, in-vitro fertilization or embryo transfer procedures
- Radial keratotomy
- Acupuncture services

- Temporomandibular joint syndrome
- Non-emergent medical services received in an emergency room
- Gender reassignment services

## Section 6: Prescription Drug Coverage

### Retail Pharmacy Prescription Drugs

Your prescription drug coverage helps to ensure that you and your family have coverage for high-quality prescription drugs with minimal out-of-pocket costs. Here are some ways to get the most out of your employer-provided prescription drug plan.

- Use generic drugs. They are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. They are approved by the Food and Drug Administration as safe, effective treatment options, and they save you money.
- Order a 90-day supply of a covered drug you use all the time. You can order through your mail order service or a retail pharmacy. Not only is this more convenient, but it can save you out-of-pocket costs on copayments.
- Take advantage of over-the-counter medications whenever possible.
- Let your doctor know right away if you are having difficulty with your prescription.
- In Michigan, when you go to a **Preferred Rx network pharmacy**, your prescriptions and refills are covered at 100 percent of the approved amount less your copayment.
- Outside Michigan, when you go to a **Medco Health Solutions, Inc. network pharmacy**, your prescriptions and refills are covered at 100 percent of the approved amount less your copayment.
- If you go to an **out-of-network pharmacy** (in Michigan or outside of Michigan), you must pay the full cost of each prescription or refill. You, not the pharmacist, will need to send a claim to us to get reimbursed. If the out-of-network pharmacy sends the claim to us, it will be rejected. Ask your pharmacist for an itemized receipt and follow the instructions in the “Filing Claims” section of the claim form. You will be reimbursed for 75 percent of the approved amount less your copayment.

### Copayment

A copayment is a flat dollar amount you must pay for eligible services.

You are responsible for a \$12 copayment for generic drugs, a \$40 copayment for formulary brand-name drugs or a \$65 copayment for non-formulary brand-name drugs.

There is a \$40 copayment for diabetic test strips and lancets.

## **Prescription Drug Benefits**

Covered drugs may be dispensed in quantities of up to a 34-day supply or, for certain maintenance drugs, 100-unit doses, whichever is greater. You have coverage for:

- Federal legend and state-controlled drugs
- Compound medications containing at least one federal legend drug ingredient
- Injectable insulin
- Needles and syringes dispensed with injectable drugs
- Contraceptive medications prescribed by a physician
- Diabetic test strips and lancets

## **Generic Equivalent Drugs**

Generic equivalent drugs can be produced by more than one manufacturer and distributed under more than one name. The Food and Drug Administration requires that these generic drugs meet the same standards for active ingredients as brand name drugs. Your pharmacist has a complete list of covered generic equivalent drugs included in your coverage. With the exception of insulin, if there is a generic equivalent to a brand name drug, your pharmacy will dispense the generic equivalent when appropriate.

If you or your physician requests a brand name drug when a generic equivalent is available, you must pay for the difference in cost between the brand name drug and the generic equivalent in addition to your copayment. If your doctor feels there are special circumstances that require you to take a brand medication instead of the generic equivalent, ask your doctor to call Medco to initiate a review.

To initiate a review:

- Ask your doctor to contact Medco at 800-753-2851
- The review process usually takes 3-5 days. Both you and your doctor are sent a letter notifying you of the approval or denial of coverage. If your brand medication is not approved, you will be responsible for the cost difference between the brand name drug and the generic drug, plus the appropriate coinsurance or copayment.

## **Co-Branded Drugs**

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

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

## **Mail Order Prescription Drugs**

BCBSM offers mail order for long-term and ongoing prescription drug needs. When you order your prescription drugs through BCBSM's mail order pharmacy, your doctor can authorize up to a 90-day supply of prescription drugs. You will only pay a copayment when you order or refill your prescription.

When you use a drug that is classified as a Specialty Drug, then you must order that drug from BCBSM's Specialty Drug mail order pharmacy. Specialty drugs require special handling, dose administration or monitoring and are used to treat complex or rare medical conditions. Some examples are:

- Arthritis drugs (such as Enbrel and Humira)
- Growth hormone drugs (such as Genotropin, Humatrope, Nutropin and Saizen)
- Hepatitis C drugs (such as Pegasys and Rebetol)
- Multiple sclerosis drugs (such as Betaseron, Copaxone and Rebif)
- Psoriasis drugs (such as Enbrel and Amevive)

To find out how to obtain mail order prescription drugs, please call the Customer Service telephone number on the back to your ID card or Medco Health at 800-778-0735. Call Walgreen's at 866-515-1355 for mail order Specialty Drugs.

## **Floor Limit**

When ordering a prescription through Medco by Mail, be sure to check your outstanding balance. You can view a summary of your account online by visiting the Medco Web site at [www.medco.com](http://www.medco.com) or call Medco at 800-778-0735.

If your outstanding balance reaches a certain amount called a "floor limit", Medco will hold your order until the balance is paid. Orders held for more than seven days because of outstanding balances will be mailed back to you unfilled. You will need to reorder the medication after you pay the balance.

If your balance reaches the floor limit (\$100), Medco will make two attempts to call you about the amount due. You can either pay over the telephone by credit card or by mail with check or money order. You may also choose to cancel any open prescription orders at that time.

## Copayment

A copayment is a flat dollar amount you must pay for eligible services.

You are responsible for a \$24 copayment for generic drugs, a \$80 copayment for formulary brand-name drugs or a \$130 copayment for non-formulary brand-name drugs.

There is a \$70 copayment for diabetic test strips and lancets.

Ordering from Medco Home Delivery Pharmacy Service involves no claim forms. Your medication is delivered to your home, postage-paid, within 10-14 business days from the date you mailed your order.

If you have questions or need more information, please call Medco Home Delivery's toll-free customer service number listed in the Customer Service Directory in the front of this handbook.

## Pharmacy Cost-Saving Programs

The BCBSM pharmacy initiatives are a series of cost-saving programs that provide additional ways to reduce drug costs. The following is a summary:

- **Member Education Therapeutic Interchange** educates about generic drugs and over-the-counter equivalents of expensive brand-name drugs. If you switch to the formulary generic or over-the-counter drugs, the generic copay will be waived for the first fill only.
- **Dose Optimization** encourages the use of select prescription drugs in once-daily dosage regimens at a lower cost rather than higher cost multiple daily doses.
- **Brand to Alternate Generic Interchange** encourages the interchange of brand-name drugs with less costly generic alternatives.
- **Generic Copay Waiver** is offered when you switch to a generic equivalent of a multi-source brand. It targets brand-name drugs that have a generic equivalent already on the market. When you agree to switch, you'll receive a one-time free copay for the generic drug.

**Note:** If your plan has a deductible and your deductible has not been met, there will be no copay to waive.

- **Brand-to-Brand Therapeutic Interchange** promotes the exchange of high-cost brand name drugs for lower-cost brand medicines that are equal in strength and efficacy.
- **Quantity Limits** restrict the dispensing of targeted drugs in quantities inconsistent with FDA-approved labeling for the drugs. Medical necessity authorization is required to dispense quantities that exceed the limit.

- **Exclude Off-Label Coverage** ensures you are using medication as recommended by the FDA. Prior authorization is required for growth hormone prescriptions **unless** the prescription is written by a pediatric endocrinologist
- **High Utilization Management and Polypharmacy** identifies and monitors potential misuses and excessive utilization of prescription drugs. Polypharmacy refers to the use of multiple medications by a member, usually from multiple physicians. Targeted members are those who are on more than 10 chronic medications or who are seeing three or more physicians within a three-month period. BCBSM will work to identify situations resulting from poorly coordinated care, drug abuse and/or prescription fraud
- **Expanding Aggressive Maximum Allowable Cost** adds more drugs to the MAC list.

## Filing Claims

To file a drug claim, do the following:

1. Obtain an itemized receipt from the pharmacy that includes the following information:
  - Date the prescription was filled
  - Name and address of the pharmacy
  - NDC (National Drug Code) number
  - Name of drug and strength
  - Quantity
  - Days supply
  - Prescription (Rx) number
  - DAW (Dispense As Written) – if applicable
2. Complete a Medco Prescriptions Direct Reimbursement Claim form for each family member.  
**Note:** Use a separate claim form for each pharmacy from which you purchase prescriptions.
3. Attach up to four itemized receipts to each claim form.
4. Review the claim form to be sure it is accurate and complete. Incomplete forms will cause your payment to be delayed. Be sure to sign each claim. Always keep a copy of your claims and receipts.
5. Mail completed claim forms to the address in the front of this handbook, which is also shown on the claim form.

## Prescription Drug Exclusions and Limitations

Exclusions and limitations that apply to your prescription drug coverage are listed below. These are in addition to applicable exclusions and limitations listed elsewhere in this handbook.

- Drugs that cost less than your copayment
- Contraceptive devices
- Administration of drugs or any drug consumed at the time and place of the prescription order
- Refills not authorized by a physician
- Therapeutic devices or appliances, even if prescribed by a physician (for example, support garments regardless of their intended use)
- More than a 34-day supply, except for specified maintenance drugs that are covered for 100-unit doses (retail pharmacy) or for mail order prescriptions that are covered for a 90-day supply
- Refills dispensed after one year from the date of the original order
- Prescription drugs prescribed for cosmetic purposes
- Any vaccine given solely to resist infectious diseases
- Any drug determined by Blue Cross Blue Shield to be experimental or investigational
- Any drug that does not require a prescription
- Drugs or services obtained before the effective date or after the contract ends
- Nonpreferred co-branded drugs, unless they are preauthorized
- Prescriptions issued by anyone who is not legally authorized to prescribe drugs for human use
- Drugs for which the cost is included in the charge for other services or supplies
- Diagnostic agents
- Any drug or device prescribed for indications (uses) other than those specifically approved by the Federal Food and Drug Administration.
- Drugs that are not labeled, "Caution: Federal law prohibits dispensing without a prescription," except for state-controlled drugs
- Covered drugs or services dispensed to a member when such services are benefits under other BCBSM certificates
- Drugs or services covered by government sponsored health care programs, such as Medicare or TRICARE
- More than 12 doses of an impotence drug such as Viagra in a 34-day period; when using mail order, more than 36 doses in a 90-day period
- Any drug approved to treat infertility
- Any drug approved for weight loss

## Section 7: Vision Care Coverage

Our Blue Vision plan promotes wellness through a comprehensive eye care program. The program is designed to provide periodic eye examinations as well as corrective eyewear and other services in order to meet your visual needs.

Blue Vision is a Preferred Provider Organization (PPO) program that uses the Vision Service Plan (VSP) provider network. Vision Service Plan is the nation's largest provider of eye care wellness benefits.

### Blue Vision Advantages

Our Blue Vision plan gives you these Blue advantages:

- Access to an extensive network of Vision Service Plan providers in all 50 states. There are more than 1,100 vision provider locations in Michigan and 24,000 locations nationwide.
- A wide selection of eyeglass frames available at each Vision Service Plan provider location
- A 20 percent discount on a second pair of prescription glasses
- Discounts on non-covered optional cosmetic lens options, such as blended lenses and scratch resistant coatings

### Questions

When you have questions about your Blue Vision coverage, contact Vision Service Plan, not Blue Cross Blue Shield. If you have questions or need more information, please call the Vision Service Plan's toll-free customer service number listed in the Customer Service Directory in the front of this handbook.

### Choosing a Provider

When you need vision care, it is important that you know the difference between Vision Service Plan network providers and out-of-network providers.

### Vision Service Plan Network Providers

A Vision Service Plan network provider, also called a Vision Service Plan member doctor, is an ophthalmologist or optometrist who participates in Vision Service Plan's network.

When covered vision services are obtained from a Vision Service Plan network provider, you'll receive the maximum level of coverage available under your plan. The Vision Service Plan network provider accepts direct payment from Vision Service Plan and accepts that payment plus any copayments as payment in full for covered services. When you visit a Vision Service Plan network provider, you also have no paperwork or claims to submit. The Vision Service Plan provider handles all paperwork and is paid directly by Vision Service Plan.

**Note:** Benefits are paid at the Vision Service Plan approved payment amount. Copayments are subtracted from the approved amount before the payment is made.

## Out-of-Network Providers

An out-of-network provider is a physician, optometrist or optician who is not a part of Vision Service Plan's network. Out-of-network providers have not agreed to accept the Vision Service Plan approved amount as full payment for covered services.

## Filing Claims for Out-of-Network Providers

Although more than 90 percent of Vision Service Plan patients receive care from Vision Service Plan doctors, you have the option of seeing an out-of-network provider. If you wish to see an out-of-network provider, Vision Service Plan will reimburse you up to the amount allowed under your plan's out-of-network reimbursement rate. When you go to an out-of-network vision provider, you should pay the entire bill when you receive services. Then send the following information to Vision Service Plan:

- An itemized receipt listing the services you received
- The name, address and phone number of the out-of-network vision provider
- The covered member's identification number as it appears on the ID card
- The covered member's name, phone number and address
- The name of the employer
- The patient's name, date of birth, phone number and address
- The patient's relationship to the covered member (such as "self," "spouse," "son," "daughter," etc.)

Claims must be sent to Vision Service Plan within six months from the date you received the vision services. Please keep a copy of the information for your records and send the originals to Vision Service Plan.

**Note:** Vision Service Plan's out-of-network reimbursement does not guarantee full payment, and Vision Service Plan cannot guarantee patient satisfaction when services are received from an out-of-network provider.

## Copayments

You are responsible for the following copayments:

- A \$10 copayment for an eye examination
- A combined \$25 copayment for frames and lenses, **or** medically necessary contacts

**Note:** When these services are obtained from an out-of-network vision provider, you are responsible for the difference between the approved amount and the amount the provider charged, less your copayment.

## Frequency Limitations

### Examinations

Eye examinations are covered once in any period of 12 consecutive months.

**Note:** We will cover only one eye examination within a 12-month period, even if an optometrist recommends that the patient obtain an examination by a physician.

### Frames and Lenses

The frequency limit for lenses, or one pair of contact lenses, is once in any 12 consecutive months. Frames are covered once in any period of 24 consecutive months.

## Vision Care Benefits

Your vision care benefits include:

### Examinations

We pay for a vision examination by an ophthalmologist or optometrist. The examination must include:

- History
- Visual acuity test
- External examination of the eyes
- Binocular measure
- Ophthalmoscopic examinations
- Tonometry (test for glaucoma) when indicated
- Medication for dilating the pupils and desensitizing the eyes for Tonometry, if necessary
- Summary of findings

### Lenses

We pay for standard eyeglass lenses when prescribed and dispensed by an ophthalmologist or optometrist.

- Lenses may be molded or ground, glass or plastic.
- Lenses must be equal in quality to the first-quality lens series made by American Optical, Bausch & Lomb or Tillyer and Univis.
- The lens blank must meet Z80.1 or Z80.2 standards of the American National Standards Institute.
- The lenses may be colorless or have Rose tints #1 or #2 if therapeutically necessary.

**Note:** The provider may charge you for additional tinting other than for medically necessary Rose tints #1 or #2.

- The lens blank of a standard lens **must not exceed** 60 millimeters in diameter.

**Note:** The provider may charge you for the difference in cost between standard and oversize lenses.

Blue Vision also covers the following special lenses:

- Myodisc
- Lenticular Myodisc
- Lenticular Aspheric Myodisc
- Aphakic

**Note:** We do **not** cover aphakic lenses for Aphakic (lack of natural lens).

- Lenticular Aphakic
- Lenticular aspheric Aphakic

**Note:** When selecting eyewear and options, please ask the doctor whether items you are choosing are covered by your Blue Vision plan.

### **Frames**

We pay for standard eyeglass frames. A wide selection of high-quality frames are covered in full, less your copayment. However, if you select frames that cost more than the plan's allowance, the difference that you'll pay is based on Vision Service Plan's low, discounted pricing.

**Note:** All Vision Service Plan provider locations are required to stock at least 100 different frames within the plan allowance.

### **Medically Necessary Contact Lenses**

We cover medically necessary contact lenses in full, when received from a Vision Service Plan network provider and **with prior approval**. When contacts are received from an out-of-network provider, we cover up to a maximum of \$210 and you are responsible for any difference between the approved amount and the amount the provider charged.

Contact lenses are considered medically necessary if:

- They are the only way to correct a member's vision to 20/70 in the better eye.
- They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature.

The fee for a contact suitability examination (an examination to determine whether you can wear contact lenses) is included in our payment for the contact lenses.

**Note:** Although a Vision Service Plan network provider can prescribe medically necessary contact lenses, he or she **must** receive prior approval from Vision Service Plan.

### **Elective Contact Lenses**

We cover elective contact lenses (contacts that are not medically necessary for the reasons listed under “Medically Necessary Contact Lenses”). You may receive elective contact lenses in-lieu of lenses and a frame. We pay a maximum of \$130 toward the contact lens, fitting costs, materials, and any follow-up evaluations for in-network providers and a maximum of \$105 for out-of-network providers. You are responsible for any difference between this amount and the amount the provider charged.

**Note:** There is no copayment for prescribed contact lenses that are not medically necessary.

### **Cosmetic Options**

Although we do not cover cosmetic options, as a Blue Vision member you will receive discounts when you purchase any of the following vision care products or services from a Vision Service Plan network provider:

- Blended lenses
- Oversize lenses (61 millimeters or greater)
- Progressive/Multifocal lenses
- Lenses tinted darker than Rose tint #2 (such as sunglasses)
- Photochromic lenses
- Scratch coating/laminating of a lens or lenses
- Cosmetic lenses/processes
- UV protected lenses

### **Vision Care Exclusions and Limitations**

Exclusions and limitations that apply to your vision care coverage are listed below. These are in addition to the exclusions and limitations listed elsewhere in this handbook.

- Additional charges for:
  - Blended lenses
  - Oversize lenses (61 millimeters or greater)
  - Progressive/Multifocal lenses
  - Lenses tinted darker than Rose tint #2 (such as sunglasses)
  - Photochromic lenses
  - Scratch coating/laminating of a lens or lenses
  - Cosmetic lenses/processes
  - Anti-reflective lenses
  - UV protected lenses
  - Two pair of glasses in lieu of bifocals

- Medical-surgical treatment
- Medications administered during any service except a vision examination
- Services not prescribed by an ophthalmologist or optometrist
- Special services, such as orthoptics, vision training, low (subnormal) vision aids and aniseikonic lenses
- Replacement of broken or lost lenses or frames
- Services received as a result of an eye disease, defect or injury due to an act of war, declared or undeclared
- Services available at no cost to you or which no charge would be made in the absence of Blue Cross Blue Shield coverage
- Charges for lenses or frames ordered while you are eligible for benefits but delivered more than 60 days after coverage ends
- Aphakic lenses when the patient lacks a natural lens
- Charges for experimental or poor quality services
- Services, eyeglasses, or contact lenses that are **not** medically necessary
- A second vision exam by a physician or any eligible provider, regardless of the purpose
- Insertion of new lenses into “old” or existing frames
- Cosmetic contact lenses that do not improve vision

## Section 8: Filing Claims

When you use your benefits, a claim must be filed before payment can be made. If you go to participating providers, you will not have to file claims for medical services because claims are submitted directly to BCBS for you. However, if you receive medical services from nonparticipating providers, or you receive care out of the country, you may be required to file your own claims.

### How to Submit a Claim

You should submit your claim as soon as you receive covered services. Generally, if you submit claims beyond the applicable filing limitation, they will be denied. The following filing limitation guidelines apply for most claims:

- Twelve months after the date of service for hospital and other facility claims.
- Fifteen months after the date of service for doctor and other medical professional claims.
- One year after the date of purchase for prescription drug claims, see the Prescription Drug Coverage section for filing instructions.

If you need a claim form, contact your employer or call a BCBS customer service representative.

To file a claim, follow these steps:

1. Obtain an itemized statement from the provider that includes the following information:
  - Name of the patient and the subscriber
  - Contract number (from your ID card)
  - Provider's name and address
  - 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)

You may include cash register receipts, canceled checks or money order stubs with your itemized receipt, but they may not substitute for an itemized receipt.

**Note:** If you receive medical services 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 U.S. currency amounts.

2. Complete a separate claim for each family member. Multiple services for the same patient may be attached to one claim.

3. Attach all itemized receipts and statements to the claim form. Make sure the subscriber's name and contract number from the BCBS ID card are on all receipts and attachments.
4. Review all claims 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 BCBS cannot return them to you.
5. Mail all claims to the address shown on the form. If you do **not** have a claim form, send the itemized receipt to your BCBS customer service office. Addresses are listed on the inside front cover of this handbook.

## Explanation of Benefits

We will send you an explanation of benefits statement after we have processed your claim. The EOB shows you what services have been paid by BCBS 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 us if you did not receive the services or if there are any discrepancies.

## Online EOB

Online EOB statements provide the same information as paper EOB statements but allow you to view statements quickly and easily 24 hours a day, seven days a week. You can access your online EOB statements by visiting **bcbsm.com (and register for Member Secured Services so you can access all of our online services)**.

Online EOB statements allow you to view statements securely from any personal computer, search for statements by date or patient name, track benefit payments, and download or print statements.

**Note:** When you sign up to receive online EOB statements, you will no longer receive paper statements through the mail.

## What to Do if a Claim is Denied

If your medical claim was not paid, in whole or in part, your EOB will indicate the reason for nonpayment.

## Your Right to Request Review of an Adverse Benefit Determination

Most questions or concerns about decisions we make on claims or requests for benefits can be resolved through a phone call to one of our customer service representatives. You can locate the phone number in the top right hand corner of the first page of your explanation of benefits statement or in the letter we send to notify you that we have not approved a request for benefits.

In addition, the Employee Retirement Income Security Act of 1974 protects you by providing you the opportunity to request review of an adverse benefit determination.

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

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

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

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

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

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

All requests for review of adverse benefit determinations must be in writing, except requests for review of urgent care claims, which may be made orally. Normally, for all three types of claims, you must exhaust our internal review procedure before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

## **Review Procedure**

### **A. Review Procedure – Post-service claims**

Under the review procedure for post-service claims, you are entitled to a two-step appeal process. We must provide you with a written determination within 30 calendar days of our receipt of your written requests for review at each level.

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

1. To initiate level 1 review, you or your authorized representative must send us a written statement explaining why you disagree with our determination. Please include in your request all documentation, records or comments you believe support your position. You must request review no later than 180 calendar days after you receive our claim decision. Mail your written request for review to the address found in the top right hand corner of the first page of your explanation of benefits statement or to the address in the letter we send notifying you that we have not approved a benefit or service you are requesting. We will respond to your request for review in writing within 30 days, unless we have notified you in writing that we need additional information to complete our review. If you agree with our response, it becomes our final determination, and the review ends.
2. If you disagree with our response to your level 1 appeal, you may then proceed to level 2. You must request level 2 review in writing no later than 30 calendar days after you receive our level 1 determination.

Mail your request to the address specified in the letter we send notifying you we have not approved your level 1 appeal.

Again, please provide all documentation, records and comments that support your position. We will provide you a written determination within 30 days of receipt of your request for level 2 review, unless we notify you in writing that additional information is needed for us to complete our review. Our written level 2 determination will be our final determination.

3. If you disagree with our final determination, or if we fail to issue our determination at each level within the 30-day time frame or otherwise fail to comply with the review procedures for level 1 or level 2, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

## **B. Review Procedure – Pre-service claims**

1. The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that we must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. We will issue our determination within 15 calendar days of receipt of your level 1 review request and within 15 calendar days of your level 2 review request. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.
2. If you disagree with our final determination, or if we fail to issue our determination at each level within the 15-day time frame or otherwise fail to comply with the review procedures for level 1 or level 2, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

### **C. Review Procedure – Urgent care claims**

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing.
2. We must provide you with our decision as soon as possible, taking into account the medical exigencies, no later than 72 hours after receipt of your request for review. All necessary information will be transmitted to you or to your authorized representative by telephone, facsimile or other available similarly expeditious method. If our decision is communicated orally, we must provide you or your authorized representative with written confirmation of our decision within two business days.
3. If you disagree with our final determination, or if we fail to issue our determination within 72 hours or otherwise fail to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to review of pre-service, post-service and urgent care claims:

- a. In writing, you may authorize another person, including but not limited to a physician, to act on your behalf at any stage in the standard internal review procedure.
- b. We do not impose any review fees or costs.
- c. Although we have set time frames within which to give you our final determination on all three types of claims, you have the right to allow us additional time if you wish.
- d. We will provide you, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.
- e. You may submit written comments, documents, records and other information relating to your claim for benefits, and we will consider this information even if it was not submitted or considered in the initial benefit determination.
- f. The person who reviews your adverse benefit determination will be someone other than the person who issued that determination. The determination we make on review will be a new determination; the initial determination we made on your claim will not be afforded deference in the review.
- g. If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the medical field or specialty involved.
- h. Upon request, we will identify the medical experts whose advice was obtained in connection with the adverse benefit determination, even if we did not rely on that advice in making the determination.

- i. On review, we will advise you of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.
- j. If we rely on an internal rule, guideline, protocol or other similar criterion in making the adverse determination, we will advise you and provide a copy of the rule, guideline, protocol or other similar criterion free of charge upon request.
- k. If the adverse benefit determination is due to lack of medical necessity or to experimental treatment, or similar exclusion, we will advise you and provide an explanation of the clinical judgment free of charge upon request.
- l. If your health plan provides for any voluntary appeal procedures beyond the level 2 review, we will advise you of those procedures in our level 2 response.

## Section 9: Other Information

This section includes helpful information about these important topics:

- Coordination of benefits
- Subrogation

### Coordination of Benefits

COB is how health care plans coordinate benefits when you are covered by more than one health care or motor vehicle insurance plan. Your company's health care plan, which is administered by us, requires that your benefit payments be coordinated with benefit payments from another health care or motor vehicle insurance plan for services that may be payable under either plan, so that payment responsibilities will be fair. If you are covered by more than one health care or motor vehicle insurance plan, COB guidelines (explained below) determine which plan pays for covered services first. COB letters of inquiry, which request information about other plans, may be sent on an annual basis in order to keep our records up to date.

The plan that pays first is your **primary plan**. This plan must provide you with the maximum benefits available to you under that plan. The plan that pays second is your **secondary plan**. This plan provides payments toward the balance of the cost of covered services — up to the total allowed amount.

COB makes sure that the level of payment, when added to the benefits payable under another plan, will cover up to the total of the eligible expenses. COB also makes sure that the combined payments of all coverage will not exceed the actual cost approved for your care.

### Guidelines to Determine Which Plan is Primary and Secondary

- If a group health plan does not have a COB provision, then that group health plan is primary.
- If a group health plan does have a COB provision, the plan that covers the patient as the employee (subscriber) is primary and pays before a plan that covers the patient as a dependent.
- If a dependent child is covered under both parents' (or legal guardians') plans, 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 Qualified Medical Child Support Order or divorce decree places financial responsibility on one parent:
  1. Plan of the custodial parent
  2. Plan of the custodial parent's new spouse (if remarried)

3. Plan of noncustodial parent
4. Plan of noncustodial parent's new spouse (if remarried)

**Note:** If custody is not known, then the birthday rule is used to determine the order of benefits for children of divorced, separated or never married parents.

When an employee is the subscriber on multiple group health insurances policies:

- If both contracts are either “active employee” or are “retired employee,” then the group health insurance in effect the longest is the primary plan, and the other contract is the secondary plan. (Note: Refers to coverage supplied by the employer group, not which health insurance carrier has supplied coverage longer)
- If one contract is “active employee” and one is “retiree/laid-off COBRA,” then the “active employee” group is the primary plan and the “retiree/laid-off COBRA” employer group is the secondary plan.
- If the primary plan cannot be determined by using the guidelines above, then the plan covering the dependent child the longest is primary.

## **Updating COB Information — Your Responsibility**

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify your employer immediately. Please help us serve you better by responding to requests for COB information quickly. We will request updated COB information yearly. If COB information such as cancellation of other coverage, switching other coverage carriers or changes in custody or court ordered coverage for dependent children is not updated, claims could reject inappropriately or send incorrect messages to your health care providers.

If the information you provided on your latest COB letter of inquiry is more than one year old and a claim is submitted under your contract for your spouse or dependent children, the claim will be temporarily held. We will send you a new letter of inquiry requesting information about other carriers. When you respond, we will update your record. Your claim will then be processed according to the appropriate COB rules.

**Important:** If you do not respond to our letter of inquiry within 50 days of its receipt, the claim will be denied due to lack of current COB information. In addition, all other claims for your spouse and dependents will be denied until the COB letter of inquiry is returned.

## **Specific Information about Your COB**

Your plan includes non-duplicative payment COB. This means:

- When your BCBSM contract is the secondary (or tertiary) payer, you remain responsible for all primary patient liability resulting from primary insurance sanctions, penalties or network restrictions, unless your primary insurer is an HMO.

- As secondary (or tertiary) payer, we will not apply contract network restrictions unless the primary insurer denied benefits for the service.
- As secondary (or tertiary) payer, we will cover the remaining non-sanctioned patient liability up to the amount we would have paid had we been primary for BCBSM covered services only.

## **Filing COB Claims to your Secondary Carrier**

Always have your health care provider submit claims to your primary carrier first. Then have your provider submit a claim for the secondary balance to BCBSM. If your provider will not submit a secondary claim to BCBSM, then you can submit the claims as follows:

1. Obtain an explanation of benefits from the primary carrier.
2. Ask your provider for an itemized receipt or detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt you received from the provider.
4. Make sure the provider's name and complete address are on your receipts. Also include the provider's tax ID number.
5. Send these items to the appropriate address as indicated on the claim.

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

## **Subrogation**

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

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

## Section 10: Glossary — Health Care Terms

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

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

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

**Approved amount** — The BCBS maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles, copayments, coinsurance and sanctions are deducted from the approved amount.

**Approved amount for prescription drugs** — Lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) paid to the pharmacy, not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

**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, and must have been approved as a BCBS provider. Approved facilities must be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

**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 BCBS.

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

**BCBS** — Blue Cross Blue Shield

**BCBSA** — Blue Cross and 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.

**BCBSM** — Blue Cross Blue Shield of Michigan, a nonprofit, independent company and 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.

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

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

**Brand-name drugs** – Prescription drugs that are patent protected. When the patent expires, other manufacturers can produce the generic equivalent of the brand and sell it under a generic name.

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

- **Phase I** – A study on a small number of patients to determine what the side effects and appropriate dose of treatment may be for a certain disease or condition.
- **Phase II** – A study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- **Phase III** – A study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

**Closed formulary**– Drugs not listed in this formulary are not covered, making the member responsible for the full cost of any nonformulary drug that is dispensed.

**COB** — Coordination of benefits, a program that coordinates your health benefits when you have coverage under more than one group health plan.

**COBRA** — Continuation coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

**Coinsurance** — The percentage of the approved amount you are required to pay for covered services.

**Colony stimulating growth factors** – Factors that stimulate the multiplication of very young blood cells.

**Copayment** — The designated portion of the approved amount you are required to pay for covered services.

**Covered services** — Services, treatments or supplies identified as payable in your employer's coverage documents. Covered services must be medically necessary to be payable, unless otherwise specified.

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

- Routine nursing care
- Training in personal hygiene and other forms of self-care
- Care supervised by a physician

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

**Designated cancer center**— A site approved by the National Cancer Institute as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

**Designated facility** — A facility that BCBS determines to be qualified to perform a specific organ transplant.

**Designated services** – Services that BCBS determines only a noncontracted area hospital is equipped to provide.

**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. This equipment must be prescribed by a physician.

**Emergency first aid** — The initial exam and treatment of conditions resulting from accidental injury.

**ESRD** — End stage renal disease, permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

**Experimental or investigative** — A service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. BCBS 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 BCBSA or other local or national bodies

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

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

**Generic drugs (Tier 1)** – Non-brand-name drugs that produce the same effects in the body as the equivalent brand-name drugs. The Food and Drug Administration requires that generic drugs have the same active ingredients as the equivalent brand name drugs. They may differ from brand-name drugs in color and shape. Since the major difference between brand-name and generic drugs is price, your prescription will be filled with the generic equivalent when medically appropriate. They also require the lowest copayment, making them the most cost-effective option for the treatment.

**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.

**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.

**Medically necessary** — A service must be medically necessary in order to be payable by your health care coverage.

Medically necessary **hospital services** are those that are:

- For the treatment, diagnosis or symptoms of an injury, condition or disease
- Appropriate for the symptoms and consistent with the diagnosis
- Not mainly for the convenience of the member or health care provider
- Not generally regarded as experimental or investigative by BCBS

Medically necessary **physician services** are determined by physicians acting for their respective provider types and medical specialty, and are based on criteria and guidelines developed by physicians and other professional providers. Medically necessary physician services are those that are:

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

- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- 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.
- Determined by a physician or professional review according to generally accepted standards and practices, in the absence of established criteria.
- Based on standards of practice established by physicians, for BCBS payment purposes.

**Medicare** — Pays health care costs for eligible persons age 65 or older. Also pays for people younger than 65 diagnosed with end stage renal disease or entitled to Social Security or Railroad Retirement benefits because of a disability for at least 24 months.

**Member** — Any person eligible for health care services under your plan. This includes you as the subscriber and any of your eligible dependents listed in BCBS membership records.

**Negotiated rate** — In most cases, a simple discount arrangement.

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

**Nonformulary Brand (Tier 3)** – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copayment for these drugs under a triple-tiered plan. Nonformulary drugs are not covered under a closed formulary plan.

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

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

- Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury, or following surgery
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living
- Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats).

**Out-of-area hospital** — A BCBSM panel or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

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

**Per claim** — A provider's acceptance of the BCBS approved amount as payment in full for a specific claim or procedure.

**Peripheral blood stem cell transplant** — A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

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

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

**Physician** — A medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of dental surgery or doctor of medical dentistry.

**Pre-existing** — A pre-existing condition exclusion is a limitation or exclusion of benefits relating to a physical or mental condition based on the fact that the condition was present before the first day of coverage. Your plan will not pay benefits for covered services rendered to treat such a condition until after the exclusion period ends.

**Preapproval** — A process that allows you or your health care provider to know if we will cover proposed services before you receive them. If preapproval is not obtained before you receive certain services, they will not be covered.

**Prior authorization** — Prior authorization saves money by limiting the prescribing of certain drugs under certain circumstances. The process requires physicians to obtain approval from BCBSM before prescribing select prescription drugs. The drugs selected for prior authorization include those with a potential for alternative use or misuse.

**Professional provider** — A medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of dental surgery, doctor of medical dentistry or a fully licensed psychologist.

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

- **Network providers** – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with BCBS to provide services to members enrolled in a PPO health care plan. Network providers have agreed to accept our approved amount as payment in full for covered services.
- **Out-of-network, participating providers** — Providers who are not part of the BCBS PPO provider network. Out-of-network, but participating providers have signed agreements with BCBS to accept the BCBS approved amount as payment in full for covered services. However, because these providers are not a part of the PPO network, you must pay higher out-of-pocket costs.
- **Out-of-network nonparticipating providers** — Providers who have not signed participation agreements with BCBS agreeing to accept the BCBS payment as payment in full. However, nonparticipating professional providers may agree to accept the BCBS approved amount as payment in full on a per claim basis.
- **Nonparticipating providers** — Providers who have not signed participation agreements with BCBS agreeing to accept the BCBS payment as payment in full. However, nonparticipating professional providers may agree to accept the BCBS approved amount as payment in full on a per claim basis.
- **Participating providers** — Providers who have signed agreements with BCBS to accept the BCBS approved amount for covered services as payment in full.

**Qualified Medical Child Support Order**— A court order or court-approved settlement agreement that provides for health benefits for a child of a group health plan participant or enforces one of the mandatory provisions of state law regarding the provision of health insurance to minors in such cases. A QMCSO gives the child the same rights as an employee to receive benefits under a group health plan.

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

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

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

**Speech Pathology Severity Guidelines for Developmental Conditions** — Severity criteria for developmental conditions are met when any of the following clinical situations are documented in the patient’s medical record:

- The child's condition is scored within the severe range on a standardized test of communicative dysfunction.
- The child's condition is scored within the severe range on a subtest of a standardized test of communicative dysfunction.
- The child is functionally non-verbal at the age of 2.5 years or older.
- The child tests at more than one year behind norms for receptive language on a standardized test of communicative dysfunction.
- The child tests at more than one year behind norms for expressive language on a standardized test of communicative dysfunction.
- The child tests at more than one year behind norms for articulation proficiency on a standardized test of communicative dysfunction.

The medical chart must demonstrate specific treatment goals based on the original and ongoing assessment of the child's speech and language disorder. Measurement of progress toward those goals must be documented.

If a child's severity status changes, as a consequence of treatment, while therapy is in progress, coverage will continue for the remainder of the 60 calendar days or 60 treatments, depending on the contract limitations.

**Speech therapy** — Active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

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

**Step therapy** – Step therapy is an automated process that ensures that only the most appropriate and cost-effective drugs are prescribed to members. The process applies a set of criteria to certain prior authorization prescriptions to determine if a less costly medication can be used for the same drug therapy. Step therapy may include use of select over-the-counter products.

**Subscriber** — The employee or COBRA qualified beneficiary who signed the enrollment form for BCBS coverage.

**Substance abuse** — Taking alcohol or other drugs in amounts that can:

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

**Syngeneic transplant** – A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient’s identical twin to transplant into the patient.

**TRICARE** — A Department of Defense health care program for members of the uniformed services and their families. This includes members of the reserves and National Guard who are called to active duty and their families.

**We, us, our** – Used when referring to BCBS.

**You and your** – Used when referring to any person covered under the subscriber’s contract.

## Section 11: General Information

Summary Plan Description - Michigan Trucking, LLC (May 1, 2008)

### Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
<p><b>Eligible Person</b></p>	<p>Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms).</p> <p>If both spouses are Eligible Persons under the Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.</p> <p>Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll.</p>	<p>We determine who is eligible to enroll under the Plan.</p>
<p><b>Dependent</b></p>	<p>Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms).</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.</p> <p>If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll.</p>	<p>We determine who qualifies as a Dependent.</p>

# When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
<p><b>Initial Enrollment Period</b> The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p><b>Open Enrollment Period</b></p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p><b>New Eligible Persons</b></p>	<p>New Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the first day of the month following the completion of a 90 day waiting period if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage.</p>
<p><b>Adding New Dependents</b></p>	<p>Participants may enroll Dependents who join their family because of any of the following events:</p> <ul style="list-style-type: none"> <li>• Birth.</li> <li>• Legal adoption.</li> <li>• Placement for adoption.</li> <li>• Marriage.</li> <li>• Legal guardianship.</li> <li>• Court or administrative order.</li> </ul>	<p>Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form and any required contribution for coverage within 31 days of the event that makes the new Dependent eligible.</p>

## When to Enroll

## Who Can Enroll

## Begin Date

### Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

**Event Takes Place** (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

**Missed Initial Enrollment Period or Open Enrollment Period.** Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

## General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

## Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
<b>The Entire Plan Ends</b>	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
<b>You Are No Longer Eligible</b>	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent".
<b>The Claims Administrator Receives Notice to End Coverage</b>	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
<b>Participant Retires or Is Pensioned</b>	<p>Your coverage ends the last day of the calendar month in which the Participant is retired or pensioned under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage.</p> <p>This provision applies unless we designate a specific coverage classification for retired or pensioned persons, and only if the Participant continues to meet any applicable eligibility requirements. We can provide you with specific information about what coverage is available for retirees.</p>

## Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Participant that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
<b>Fraud, Misrepresentation or False Information</b>	Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
<b>Material Violation</b>	There was a material violation of the terms of the Plan.
<b>Improper Use of ID Card</b>	You permitted an unauthorized person to use your ID card, or you used another person's card.
<b>Failure to Pay</b>	You failed to pay a required contribution.
<b>Threatening Behavior</b>	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

## Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

## **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**

Group health plans and health insurance issuers generally may not, under federal law, 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, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **Determinations of Qualified Medical Child Support Orders:**

The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participants' rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

## **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

### **Eligible Leave**

An Associate who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

### **Contributions**

During this leave, the Employer will continue to pay the same portion of the Associate's contribution for the Plan. The Associate shall be responsible to continue payment for eligible Dependent's coverage and any remaining Associate contributions. If the covered Associate fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

### **Reinstatement**

If coverage under the Plan was terminated for failure to make the required contribution during an approved FMLA leave, and the Associate returns to active work immediately upon completion of that

leave, Plan coverage will be reinstated on the date the Associate returns to active work as if coverage had not terminated, provided the Associate makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

### **Repayment Requirement**

The Employer may require Associates who fail to return from a leave under FMLA to repay any contributions paid by the Employer on the Associate's behalf during an unpaid leave. This repayment will be required only if the Associate's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the Associate's control.

## **MILITARY MOBILIZATION**

If an Associate or an Associate's Dependent is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the Associate or the Associate's Dependent may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the Associate or Associate's Dependent may not be required to pay more than the Associate's share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the Employer may require the Associate or Associate's Dependent to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

- Eighteen (18) months beginning on the day that the leave commences, or
- A period beginning on the day that the leave began and ending on the day after the Associate fails to return to employment within the time allowed.

The Associate's coverage, and the Associate's Dependent coverage if elected, will be reinstated without exclusions or a waiting period. Summary Plan Description

**Name of Plan:** Michigan Trucking, LLC Welfare Benefit Plan

### **Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:**

Michigan Trucking, LLC  
6000 Clay Avenue SW  
Grand Rapids, MI 49548  
(616) 530-8558

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

**Employer Identification Number (EIN):** 27-1248467

**IRS Plan Number:** 501

**Effective Date of Plan:** May 1, 2008

**Type of Plan:** Group health care coverage plan

**Name, Business address, and Business Telephone Number of Plan Administrator:**

Michigan Trucking, LLC  
6000 Clay Avenue SW  
Grand Rapids, MI 49548  
(616) 530-8558

**Claims Administrator:** The company which provides certain administrative services for the Plan.

Blue Cross Blue Shield of Michigan  
600 East Lafayette Street  
Detroit, Michigan 48226  
888-890-5707

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

**To Request a Certificate of Creditable Coverage, contact:**

Blue Cross Blue Shield of Michigan  
600 East Lafayette Street  
Detroit, Michigan 48226  
888-890-5707

**Type of Administration of the Plan:** The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a provider network established by Blue Cross Blue Shield. The named fiduciary of Plan is Michigan Trucking, LLC, the Plan Sponsor.

**Person designated as agent for service of legal process:**

Service of process may also be made upon the Plan Administrator.

**Source of contributions under the Plan:** There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

**Method of calculating the amount of contribution:** Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

**Date of the end of the year for purposes of maintaining Plan's fiscal records:** The Plan year shall be a twelve month period ending March 31.

**Determinations of Qualified Medical Child Support Orders:**

The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participants' rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

## **Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

## **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

## **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, 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. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan

Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States 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 publication hotline of the Employee Benefits Security Administration. Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

## **Continuation Coverage under Federal Law (COBRA)**

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former spouse.

## **Qualifying Events for Continuation Coverage under Federal Law (COBRA)**

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of employment, for any reason other than gross misconduct.
- B. Reduction in the Participant's hours of employment.

With respect to a Participant's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

- A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct).
- B. Reduction in the Participant's hours of employment.
- C. Death of the Participant.
- D. Divorce or legal separation of the Participant.
- E. Loss of eligibility by an Enrolled Dependent who is a child.
- F. Entitlement of the Participant to Medicare benefits.
- G. The Plan Sponsor's commencement of a bankruptcy under Title 11, United States Code. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

## **Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)**

### **Notification Requirements for Qualifying Event**

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the latest of the date of the following events:

- The Participant's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.
- The date the Qualified Beneficiary would lose coverage under the Plan.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Participant or other Qualified Beneficiary must also notify the Plan Administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

### **Notification Requirements for Disability Determination or Change in Disability Status**

The Participant or other Qualified Beneficiary must notify the Plan Administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Plan Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

The Qualified Beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

## Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying events A and B).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B, then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

- Notice of such disability must be provided within the latest of 60 days after:
  - ◆ the determination of the disability; or
  - ◆ the date of the qualifying event; or
  - ◆ the date the Qualified Beneficiary would lose coverage under the Plan; and
  - ◆ in no event later than the end of the first eighteen months.
- The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
- If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).
- C. With respect to Qualified Beneficiaries, and to the extent that the Participant was entitled to Medicare prior to the qualifying event:
- Eighteen months from the date of the Participant's Medicare entitlement; or
  - Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.
- D. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:
- Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:
    - ◆ The Participant's Medicare entitlement occurs within the eighteen month continuation period; and
    - ◆ Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the Plan for failure to make timely payment of the premium.

- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.
- H. The date the entire Plan ends.
- I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.



**These codes relate to your health care plan and are for internal use by BCBSM.**

<b>Group Name:</b>	Michigan Trucking, LLC		
<b>Funding:</b>	ASC		
<b>Suffix:</b>	N/A	<b>System:</b>	NASCO
<b>Effective date of coverage:</b>	04/01/10	<b>ERISA Exempt?</b>	No
<b>Print Date:</b>	05/21/10	<b>PA 250 applicable?</b>	No
<b>Developer:</b>	BLW		

<b>Group Number</b>	<b>Package Code</b>	<b>Section Code</b>
71394	010	1000, 1100, 6000, 6100