FLINT PLUMBING & PIPEFITTING
INDUSTRY HEALTH CARE FUND
BENEFITS GUIDE
January 2008
COMMUNITY Blue[SM] PPO

Benefit Chart – Active Participants and Pre-Medicare Retirees

The following benefit chart is designed to provide you with a **summary** of the services covered under your plan. You will need to reference the actual certificate(s) and rider(s) for detailed information about a benefit including any exclusions or limitations.

Deductibles, Co-pays, and Dollar Maximums

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits		**In-Network**	**Out-of-Network**
Deductible		None	$250 for one member or $500 for the family each calendar year
Co-pays	Fixed dollar co-pays	• $15 for office visits, and • $50 for emergency room visits	$50 for emergency room visits
	Percent co-pays	50% of approved amount for mental health care, substance abuse treatment, and private duty nursing	• 20% of approved amount for general services, and • 50% of approved amount for mental health care, substance abuse treatment, and private duty nursing
Co-pay dollar maximum	Fixed dollar co-pays	None	None
	Percent co-pays – **excludes** mental health care, substance abuse treatment, and private duty nursing co-pays	None	20% out-of-network co-pays limited to an out-of-pocket maximum of $2,000 per member or $4,000 for the family each calendar year. Once the co-pay maximum has been reached, out-of-network claims are to be reimbursed at 100% of the approved amount for the remainder of the year.
Lifetime benefit dollar maximum		$1 million lifetime per covered specified human organ transplant type and a **separate** $5 million lifetime per member for all other covered services and as noted for individual services	

Preventive Care Services

***Payment for preventive care services is limited to a combined maximum of $250 per member per calendar year.**

Benefits	In-Network	Out-of-Network
Health maintenance exam – includes chest X-ray, EKG, and select lab procedures, one per calendar year	Covered – 100% approved amount*	Non covered
Gynecological exam – one per calendar year	Covered – 100% of approved amount*	Not covered
Pap smear screening – laboratory and pathology services, one per calendar year	Covered – 100% of approved amount*	Not covered
Well-baby and child care visits: • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Covered – 100% of approved amount*	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics. **Note:** There is no age limit for the Hepatitis B immunization.	Covered – 100% of approved amount*	Not covered
Fecal occult blood screening – one per calendar year	Covered – 100% of approved amount*	Not covered
Flexible sigmoidoscopy exam – one per calendar year	Covered – 100% of approved amount*	Not covered
Prostate specific antigen (PSA) screening – one per calendar year	Covered – 100% of approved amount*	Not covered

Mammography

Benefits	In-Network	Out-of-Network
Mammography screening – one per calendar year, no age restrictions	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office visits	Covered - $15 co-pay	Covered – 80% of approved amount after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible, must be medically necessary
Office consultations	Covered - $15 co-pay	Covered – 80% of approved amount after deductible, must be medically necessary
Urgent care visits	Covered - $15 co-pay	Covered – 80% of approved amount after deductible, must be medically necessary

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital emergency room	Covered - $50 co-pay for facility charges (waived if admitted or if injury is the result of an accidental injury)	Covered - $50 co-pay for facility charges (waived if admitted or if injury is the result of an accidental injury)
Ambulance services – must be medically necessary	Covered – 100% of approved amount	Covered – 100% of approved amount

Diagnostic Services

Benefits	In-Network	Out-of-Network
Laboratory and pathology services	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Diagnostic tests and X-rays	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Therapeutic radiology	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible

Maternity Services Provided by a Physician or Certified Nurse Midwife

Benefits	In-Network	Out-of-Network
Prenatal and postnatal care	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Delivery and nursery care	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – unlimited days **Note:** Nonemergency services must be rendered in a **participating** hospital.	Covered - 100% of approved amount	Covered – 80% of approved amount after deductible
Inpatient consultations	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Chemotherapy	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Skilled nursing care – up to 120 days per member per calendar year	Covered – 100% of approved amount	Covered – 100% of approved amount
Hospice care – limited to dollar maximum that is reviewed and adjusted periodically	Covered – 100% of approved amount	Covered – 100% of approved amount
Home health care – must be medically necessary and provided and billed by a **participating** home health care agency	Covered – 100% of approved amount	Covered – 100% of approved amount
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	Covered – 100% of approved amount	Covered – 100% of approved amount

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery – includes related surgical services and medically necessary facility services provided by a BCBSM **participating** ambulatory surgery facility	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Presurgical consultations – with a doctor of medicine, osteopathy, podiatry or an oral surgeon	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Voluntary sterilization	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Voluntary abortions	Not covered	Not covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified human organ transplants – **in designated facilities only**, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% of approved amount, limited to a $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504); specific criteria apply	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Kidney, cornea, and skin	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible

Mental Health Care and Substance Abuse Treatment

Benefits		In-Network	Out-of-Network
Inpatient mental health care – unlimited days		Covered – 50% of approved amount	Covered – 50% of approved amount after deductible
Inpatient substance abuse treatment – unlimited days, up to $15,000 annual, $30,000 lifetime maximum		Covered – 50% of approved amount	Covered – 50% of approved amount after deductible
Outpatient mental health care	In a facility or clinic	Covered – 50% of approved amount	Covered – 50% of approved amount
	In the physician's office	Covered – 50% of approved amount	Covered – 50% of approved amount after deductible
Outpatient substance abuse treatment – up to the state-dollar amount that is adjusted annually, in approved facilities only		Covered – 50% of approved amount	Covered – 50% of approved amount

Other Covered Services

Benefits		In-Network	Out-of-Network
Outpatient diabetes management program		Covered – 100% of approved amount	Covered -80% of approved amount after deductible
Allergy testing and therapy		Covered – 100% of approved amount	Covered – 60% of approved amount after deductible
Chiropractic spinal manipulation – a maximum of 24 visits (network and non-network providers **combined**) per member per calendar year		Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Outpatient physical, speech, and occupational therapy – a **combined** 60 -visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office	In a facility or clinic	Covered – 100% of approved amount	Covered – 100% of approved amount
	In the physician's office – **excludes speech and occupational therapy**	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible
Durable medical equipment		Covered – 100% of approved amount	Covered – 100% of approved amount
Prosthetic and orthotic appliances		Covered – 100% of approved amount	Covered – 100% of approved amount
Private duty nursing		Covered – 50% of approved amount	Covered – 50% of approved amount

Temporary Benefits for Hospital Services. When a hospital chooses to terminate its participating contract with BCBSM, your coverage provides temporary benefits for emergency care and for certain services for up to six months from the date the hospital terminates its participating contract with Blue Cross Blue Shield of Michigan

Benefit Chart – Supplement to Medicare Retirees Blue Cross Blue Shield of Michigan

This document is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield certificate and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare Handbook (available on the Medicare Web site at **www.medicare.gov** or at any Social Security office).

Blue Cross Blue Shield of Michigan Supplemental Coverage is available only to individuals enrolled in <u>both</u> Medicare Part A and Part B.

Participants are given an annual option to enroll in either the Blue Cross Blue Shield of Michigan Supplemental Coverage or the Blue Care Network Advantage Program.

	Medicare	**Blue Traditional Supplemental Coverage** Blue Cross Option 2 and Blue Shield Option 1 with Master Medical 65
Preventive Care Services		
Health Maintenance Exam	Not covered	Not covered
Gynecological Exam	Not covered	Not covered
Pap Smear Screening – laboratory services only	Covered at Medicare approved amount, once every 24 months	Covered in full by Medicare
Well-baby and Child Care	Not covered	Not covered
Immunizations • Flu Shots and Pneumonia Vaccines	Covered at Medicare approved amount	Covered in full by Medicare
• Hepatitis B Vaccines – for those at risk of contracting the disease	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered
Prostate Specific Antigen (PSA) Test	Covered at Medicare approved amount, once every 12 months over age 50	Covered in full by Medicare
Mammography		
Mammography Screening	Covered at Medicare approved amount less Part B coinsurance, once every 12 months at age 40 and older	Covers Medicare coinsurance
Physician Office Services		
Office Visits	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered
Outpatient and Home Visits	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered
Office Consultations	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered

Emergency Medical Care

Hospital Emergency Room (professional services) – must be medically necessary	Covered at Medicare approved amount less Part B deductible and coinsurance or set co-payment	Covers Medicare deductible and coinsurance or set co-payment
Ambulance Services – must be medically necessary	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance

Clinical Laboratory Services

Laboratory and Pathology Tests – used in the diagnosis and treatment of an illness or injury	Covered at Medicare approved amount	Covered in full by Medicare

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies • Days 1-60	Covered at Medicare approved amount less Part A deductible	Covers Medicare deductible
• Days 61-90	Covered at Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
Hospital Care (continued)		
• Lifetime Reserve Days (60 days)	Covered at Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Additional days	Not covered	Covered at BCBSM approved amount, up to 275 days; additional days under MM65 at BCBSM approved amount
Chemotherapy	Covered for administration and drugs, at Medicare approved amount less deductible and coinsurance; must meet Medicare criteria	Covers Medicare deductible and coinsurance; pays chemotherapy drugs which Medicare does not cover; must meet BCBSM criteria for payment

Alternatives to Hospital Care

Skilled Nursing Facility Care – specific criteria applies • Days 1-20	Covered at Medicare approved amount	Covered in full by Medicare
• Days 21-100	Covered at Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
• Days 101 and after	Not covered	Not covered

Hospice Care	Covered at Medicare approved amount less small co-payment for outpatient drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home Health Care – medically necessary	Covered at Medicare approved amount	Covered in full by Medicare

Surgical Services Provided by a Physician

Surgery – includes related surgical services	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance

Human Organ Transplants

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

Heart and Liver	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance
Lung and Heart-lung	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance
Pancreas	Not covered **Note**: Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered **Note**: Covers Medicare deductible and coinsurance when covered by Medicare.
Cornea	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance
Bone Marrow and Kidney	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance

Mental Health Care

Inpatient Mental Health Care in psychiatric facility • Days 1-190 **lifetime**	Covered at Medicare approved amount less deductible and coinsurance **Note**: In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and coinsurance
• Additional days after 190 lifetime days are used	Not covered	Covered under MM65 less MM65 deductible and co-pay*
Outpatient Mental Health Care	Covered at Medicare approved amount less Part B deductible and coinsurance or set co-payment for therapeutic services. Diagnostic services are covered at the Medicare approved amount less Part B deductible and coinsurance.	Covers Medicare deductible and coinsurance or set co-payment

Other Services

Allergy Testing and Therapy – with approved diagnosis	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic Spinal Manipulation – must be medically necessary	Covered when medically necessary, at Medicare approved amount less Part B deductible and coinsurance	Not covered
Outpatient Physical, Speech and Occupational Therapy	Covered at Medicare approved amount less Part B deductible and coinsurance or set co-payment **Note**: Services of independent physical or occupational therapist subject to annual dollar limit.	Covers Medicare deductible and coinsurance or set co-payment

Durable Medical Equipment	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance
Prosthetic Appliances	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance
Private Duty Nursing	Not covered	Covered under MM65 less MM65 deductible and co-pay*
Prescription Drugs	Not covered	Not covered
Oral Cancer Drugs	Approved drugs are covered	Covered in full by Medicare

Foreign Travel

Hospital Services	Not covered, except for inpatient hospital services in Canada or Mexico in rare situations	Covered at BCBSM approved amount, up to 30 days for covered services
Physician Services	Not covered, except for services rendered in Canada or Mexico in connection with a covered inpatient stay	Covered up to BCBSM approved amount

*Master Medical 65 coverage requires a $100 deductible per member each calendar year. After the deductible is met, member pays a 20 percent co-pay (50 percent co-pay for private duty nursing). Master Medical 65 benefits are payable up to $2,500 per member per calendar year, with a lifetime maximum of $5,000. Once member reaches the $5,000 maximum, an additional $1,000 allowance is restored each calendar year of continuous coverage.

BLUE CROSS COMPLEMENTARY OPTION 2, BLUE SHIELD COMPLEMENTARY OPTION 1, GCPD, GPCSAT2, MM65, MM65AL, MMCPD Oct.2006/tks

Benefit Chart – Supplement to Medicare – Blue Care Network Advantage

BCN Advantage is available only to individuals enrolled in <u>both</u> Medicare Part A and Part B. Participants are given an annual option to enroll in either the Blue Cross Blue Shield of Michigan Supplement to Medicare Program or the Blue Care Network Advantage Program.

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or co-pay amounts required by the plan. Services must be provided or arranged by member's primary care physician or health plan.

Preventive Services

Health Maintenance Exam	Covered – $10 co-pay
Annual Gynecological Exam	Covered – $10 co-pay
Pap Smear Screening – laboratory services only	Covered – Office visit co-pay may apply per member, per visit
Well-Baby and Child Care	Covered – $10 co-pay
Immunizations – pediatric and adult	Covered – Office visit co-pay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit co-pay may apply per member, per visit

Mammography

Mammography Screening	Covered – Office visit co-pay may apply per member, per visit

Physician Office Services

Office Visits	Covered – $10 co-pay
Consulting Specialist Care – when referred	Covered – $10 co-pay

Emergency Medical Care

Hospital Emergency Room – co-pay waived if admitted, inpatient hospital benefits apply	Covered – $50 co-pay
Urgent Care Center	Covered – $10 co-pay
Ambulance Services – medically necessary	Covered – 100%

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit co-pay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – Office visit co-pay may apply per member, per visit
Radiation Therapy	Covered – Office visit co-pay may apply per member, per visit

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – $10 co-pay
Delivery and Nursery Care	Covered – 100%

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%; unlimited days
Outpatient Facility Services	Covered – 100%

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 730 days per benefit period
Hospice Care	Covered – 100%
Home Health Care	Covered - 100%. Doctor visit $10 co-pay

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100%
Voluntary Sterilization	Covered – 100%
Human Organ Transplants	Covered – 100%, subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	**Mental Health Care**: Covered – 100%, up to 190 days Medicare lifetime maximum. Additional 45 days per episode of illness after Medicare benefit is exhausted and 60 consecutive days have elapsed from last date of discharge. Then 45 days renewable after 60 days out between admissions. **Substance Abuse Care:** Covered – 100%, unlimited days
Outpatient Mental Health Care	Covered – 100%, unlimited visits
Outpatient Substance Abuse Care	Covered – 100%, unlimited visits

Other Services

Allergy Testing and Therapy	Covered – Office visit co-pay may apply per member, per visit
Allergy Injections	Covered – Office visit co-pay may apply per member, per visit
Chiropractic Spinal Manipulation – when referred	Covered – $10 co-pay
Outpatient Physical, Speech and Occupational Therapy	Covered – $10 co-pay
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 100%
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%
Prescription Drugs	Covered - $10 generic, $20 brand without contraceptives up to a 34-day supply. Drugs for the treatment of sexual dysfunction have a 50% co-pay. Mail order at two times the applicable co-pay for up to a 90 day supply. Part D out-of-pocket costs over $3,850, co-pay is the greater of 5% or $2.15 generic and $5.35 brand.

Deductible, Co-pays and Dollar Maximums

Deductible	None
Co-pays • Fixed Dollar Co-pay	$10 for office visits, $10 for urgent care and $50 for emergency room visits
• Percent Co-pay	None
Co-pay Dollar Maximums • Fixed Dollar Co-pay	None
• Percent Dollar Co-pay	None
Dollar Maximums	None

BCNA, 10OVCR, UR10, ER50, SN730, MMHX, 1020PD, MOPD2C, PD3600

BCBSM Preferred Rx[SM] Prescription Drug Coverage

Benefit Chart - ALL ELIGIBLE PARTICIPANTS

The following benefit chart is designed to provide you with a **summary** of the services covered under your plan. You will need to reference the actual certificate(s) and rider(s) for detailed information about a benefit including any exclusions or limitations.

Note: Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions for rheumatoid arthritis. These drugs require special handling, administration or monitoring.

Option Care will handle mail order prescriptions **only** for specialty drugs. Continue to send other mail order prescription medications to Medco. A list of specialty drugs is available on our Web site at **bcbsm.com.** If you have any questions, please call **Option Care customer service at 866-515-1355**.

Choosing your pharmacy

The amount you pay in out-of-pocket costs depends on whether or not you use a network or non-network pharmacy. You will have the least out-of-pocket costs when you use network pharmacies.

A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

> **Important**: Pharmacies outside of Michigan must use the MedImpact BIN and PC number below to verify your eligibility, not the five-digit group number on your ID card.

MedImpact Rx BIN 003585/Rx PCN 23615

If the pharmacist needs assistance, he or she may call the MedImpact Provider Help Desk at 800-239-1023.

Co-payments

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated “Dispensed as Written” (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable co-pay.

Benefits	Network Pharmacy	Non-Network Pharmacy
Generic drugs	$15 for each generic drug	$15 for each generic drug ***plus*** 25% of the BCBSM approved amount for the drug
Brand name drugs	$25 for each brand name drug	$25 for each brand name drug ***plus*** 25% of the BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	$15 for mail order generic drugs and $25 for mail order brand name drugs	No coverage

Covered Services

Benefits	Network Pharmacy	Non-Network Pharmacy
Federal legend drugs	Covered – 100% of approved amount less plan co-pay	Covered – 75% of approved amount less plan co-pay
State-controlled drugs	Covered – 100% of approved amount less plan co-pay	Covered – 75% of approved amount less plan co-pay
Disposable needles and syringes – dispensed with insulin or other covered injectable legend drugs	Covered – 100% of approved amount less plan co-pay	Covered – 755 of approved amount less plan co-pay
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	Covered – 100% of approved amount less plan co-pay	No coverage
Weight loss drugs	Not covered	Not covered
Impotence drugs	Not covered	Not covered
Infertility drugs	Not covered	Not covered

Comprehensive Preferred Group Dental Coverage

Benefit Chart – ACTIVE PARTICIPANTS ONLY

The following benefit chart is designed to provide you with a **summary** of the services covered under your plan. You will need to reference the actual certificate(s) or rider(s) for the detailed information about a benefit including any exclusions or limitations.

Only participants that are eligible by employer contributions or active participant self-payments are eligible for this benefit.

Choosing your provider

Blue Traditional Plus gives you **two** options for choosing a dentist. The main difference between the options is your out-of-pocket costs. Here's how your choice determines your out-of-pocket costs.

Blue Participating Dentists – These dentists participate with BCBSM on a *"per claim"* basis, so it's important to ask if your dentist participates before every procedure. If your dentist participates, it means he or she will accept our approved amount, less your co-pay, as payment in full for covered services.

Participating dentists file your claims and receive payment directly from us. You are responsible only for your co-pays, charges that exceed the annual dollar maximum, and any charges for any non-covered services.

Nonparticipating Dentists – If your dentist chooses **not** to participate with us, **your dentist can bill you for any differences between our approved amount and his or her charges**. This would be in addition to your co-pays and charges for any non-covered services.

Although a nonparticipating dentist can file claims for you, it is submitted as "pay subscriber," which means we send you the payment and you are responsible for paying the dentist.

Co-pays and Dollar Maximums

Benefits	Out-of-Pocket Costs
Co-pay	50% of approved amount
Dollar maximum	$1,000 per member per calendar year

Class I Services

Benefits	Out-of-Pocket Cost
Oral exam – once every six consecutive months	Covered – 50% of approved amount
Teeth cleaning – once every six consecutive months	Covered – 50% of approved amount
Bitewing X-rays – once every six months	Covered – 505%of approved amount
Full-mouth X-rays – once every 36 months	Covered – 50% of approved amount
Fluoride treatment	Covered – 50% of approved amount
Space maintainers – up to age 19	Covered – 50% of approved amount
Palliative emergency treatment	Covered – 50% of approved amount

Class II Services

Benefits	Out-of-Pocket Cost
Fillings (amalgam, acrylic, or silicate)	Covered – 50% of approved amount
Inlays, onlays, and crowns	Covered – 50% of approved amount
Root canal therapy	Covered – 505%of approved amount
Periodontic treatments	Covered – 50% of approved amount
General anesthesia	Covered – 50% of approved amount
Oral surgery including extractions	Covered – 50% of approved amount
Repairs to existing dentures	Covered – 50% of approved amount

Class III Services

Benefits	Out-of-Pocket Cost
Removable dentures	Covered – 50% of approved amount
Fixed bridges	Covered – 50% of approved amount

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

These are the codes for your Certificates and riders and are for internal use by BCBSM.

1700-TBHD
3553-PD-CR $15.00
3607-PREFERRED RX
394846-MOPDw/BC10 w/15
4725-XVA
480802-505050-1000
516302-BC$10 W$15PREF
5216-ECIP
5385-CRNA
5515-CB-MHP
5794-CB-OV $15.00
6225-COMM BLUE BASIC
6600-CNM
6603-CB-PCB
663415-RXXID-1 w/$15
663814-RXXID-2 w/$15
664014-RXXWL w/415
8496-ASC MOD 258
993009-GLE-1

Tracking Number 222345

Service Key	Effective Date
C1A15P	07/01/2003
S1AL16	07/01/2003

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

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 program for your Health Care Fund. Blue Cross Blue Shield of Michigan does not insure the coverage. Benefits and future changes in benefits are the responsibility of your Health Care Fund. Information concerning members may be reviewed by your Health Care Fund and Blue Cross Blue Shield of Michigan.

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.

How your PPO plan works

The following are general guidelines about your PPO health care plan. Please refer to your certificate and riders for detailed information regarding the limitations and exclusions of your health care plan.

Referrals

You can self-refer to any PPO provider and remain in-network. However, referrals to **non-network** providers must be **coordinated by your PPO** provider to remain payable at the in-network level of benefits. It is important to remember that a referral **does not guarantee payment**. To be covered, the referred service must still be a covered benefit under your health care plan.

> **Note:** If you are referred to a non-network, nonparticipating provider, you are responsible for any difference between the provider's charge and our approved amount.

Limited network

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

> **Note:** For out-of-network providers **payment is based on whether or not they are a BCBSM participating or nonparticipating provider with our Traditional plans.**

Emergency care

When you think emergency care is needed, go to the nearest medical facility. The initial exam to treat a medical emergency or accidental injury is covered at the in-network level of benefits. However, any follow up care that is required is not considered emergency care and is subject to network guidelines.

Experimental services

We do not pay for experimental services. Facility services and physician services, including diagnostic tests related to experimental procedures are also not payable. Please refer to your certificate for an explanation on how we determine experimental services.

Pain management

BCBSM 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 pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to contract limitations.

Customer service

Our goal is to provide excellent service. When you call, please have your contract number ready and, if you are inquiring about a claim, we will also need the following information:

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

Please remember, Blue Cross Blue Shield of Michigan follows strict privacy policies in accordance with state and federal law. For example, **we never release your health information to anyone, unless you have authorized BCBSM to do so in writing.** You can find the necessary release documents and forms on our Web site at www.bcbsm.com.

Calling BCBSM

To call us, please use the phone number **printed on the back of your ID card**. This number can also be found on your Explanation of Benefit (EOB).

Our customer service hours are Monday through Friday from 8:30 a.m. to 5 p.m.

For **hearing or speech-impaired** members, please call:

Area codes 248, 313, 586, 734, 810 and 947 ..... (313) 225-6903
Area codes 231, 269, and 616..... 1-800-867-8980

Writing to BCBSM

To write us, please use the address located in the upper right-hand corner of your EOB. If you do not have an EOB, please send your inquiry to:

Blue Cross Blue Shield of Michigan
Customer Service Center
P.O. Box 2888
Detroit, MI 48231

Or

Blue Cross Blue Shield of Michigan
West Michigan Customer Service Center
P.O. Box 894
Grand rapids, MI 49518

Receive your Explanation of Benefits statements electronically

From the secured area of our web site, you can view, save or print your EOB statements. If you haven't already signed up for this valuable feature, visit BCBSM at www.bcbsm.com.

Visiting Blue Cross Blue Shield of Michigan

We have customer service representatives available at BCBSM customer service offices located across Michigan. Our offices are open from 8:30 a.m. to 5 p.m., weekdays, unless otherwise noted.

Alpena
135 W. Chisholm St.
On the main street in downtown Alpena

Detroit
500 Lafayette East
Open 8:30 a.m. to 4:30 p.m.
Downtown, three blocks north of Jefferson at I-375

Flint
4520 Linden Creek Parkway, Suite A

Grand Rapids
86 Monroe Center, N.W.
Open 8:30 a.m. to 12:00 p.m. and 1 to 5 p.m.

Holland
259 Hoover Blvd., Suite 160
Near U.S. 31 and 8th St.

Jackson
2282 Springport Road, Suite H
Open 8:30 a.m. to 12:00 p.m. and 1 to 5 p.m.
In Springport Center ½ mile West of U.S. 127

Lansing
1405 S. Creyts Road
Open 8:30 a.m. to 4:30 p.m.
¼ mile south of I-496, Creyts road Exit

Marquette
415 South McClellan Ave.
Up on the hill

Mt. Pleasant
1620 South Mission
In Campus Court Shopping Mall

Muskegon
1034 E. Sternberg Road
The Pointes

Portage
2255 W. Centre Ave.
1 mile east of Centre Ave. exit off Route 131 at Oakland Drive (next to Bank One)

Port Huron
1924 Pine Grove Ave.
Behind Global Insurance

Saginaw
4300 Fashion Square Blvd.
¼ mile south of the Fashion Square mall

Traverse City
1769 S. Garfield Ave.
Across from Cherryland Center

Utica
6100 Auburn Road
Diagonally, across from AAA Building

Visiting BCBSM on the Web

Our Web site offers many valuable resources to help you manage your insurance needs as well as your health. At www.bcbsm.com, you can:

- Verify eligibility and coverage for everyone on your contract
- Request additional ID cards
- Receive EOB statements electronically
- Take a Health Risk Assessment
- Read health tips, articles and preventative information
- Research a health condition

Your BCBSM ID card

This section provides information on using your BCBSM health care plan.

Your Identification card

Once enrolled, you'll receive an ID card(s). All cards will show the subscriber's name, even those issued to dependents.

Contract number: The subscriber's assigned contract number with BCBSM.

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

Enrollee name: The subscriber's name as it appears on our membership records.

Group number: A unique five-digit group number identifying the sponsors of the health care plan.

About your ID card

- Only you and your eligible dependents may use the cards issued for your contract. Lending your card is illegal and subject to possible fraud investigation and termination of coverage.

- Call BCBSM if your card is lost or stolen. Your provider can call BCBSM to verify coverage until you received your new cards.

- You will receive new ID cards only when there is a change in your benefit plan.

- If you need additional ID cards, you can order them through our Web site at www.bcbsm.com or by calling our customer service office.

Preventing fraud

If your provider asks for another form of identification don't worry. Checking a cardholder's identification is just one way our providers help BCBSM protect you against unauthorized use of your card.

You can also help prevent fraud by checking Explanation of Benefit (EOB) forms. If you see a discrepancy on your EOB, contact your provider first to see if it is an error. If it's not and you believe it is fraudulent billing or use of your card, then let BCBSM know by calling our Anti-Fraud Hotline at 1-800-482-3787. You can also write to BCBSM at the following location, or visit BCBSM online at www.bcbsm.com.

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

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

Enrollment and membership

Your Health Care Fund determines the effective date of your health care plan with BCBSM. If you have questions about this date, please check with the Fund Office.

Making membership changes

To request a membership change for one of the reasons listed below, you will need to complete and return to the Fund Office an **Enrollment/Change of Status** form. Please contact the Fund Office to obtain this form.

- Name or address change
- Adding or removing a dependent
- Cancellation of your contract
- Medicare eligibility and enrollment

To avoid delays in payments, misdirected communications, or potential coverage problems, it's important that you return this form **within 30 days** of when the event occurs. This is especially important **when adding or removing a dependent from your contract because you can be liable for claims paid in error.** For example, in the case of divorce, if you fail to give timely notice you may be responsible for payments made by BCBSM on behalf of your ex-spouse for services provided subsequent to your divorce date.

Continuing coverage on your own

Coverage ends for you and your dependents when you are no longer eligible for coverage through the Flint Plumbing & Pipefitting Industry Health Care Fund. However, you may continue coverage under one of these options:

1. Continue **temporary** coverage through the Flint Plumbing & Pipefitting Industry Health Care Fund under the self-payment program; **or**

2. Continue temporary coverage through the Flint Plumbing & Pipefitting Industry Health Care Fund under a federal legislative act known as **COBRA** (Consolidated Omnibus Budget Reconciliation Act), **or**

3. Convert to BCBSM's individual coverage, called **Group Conversion**

Your certificate provides an explanation for both options; however, you will need to contact the Fund Office to clarify eligibility dates and to select the type of coverage that will best meet your needs.

For additional information on COBRA or Group Conversion, please refer to your health care certificate.

Certificate of creditable coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any pre-existing condition exclusion periods that might otherwise apply when changing coverage. When your coverage through your Health Care Fund ends, you will receive a certificate of creditable coverage. You also may request a certificate for health coverage for periods of coverage on and after July 1, 1996, at any time during your coverage or within 24 months of loss of coverage. To request a certificate of creditable coverage, please call BCBSM at 1-800-292-3501.

Health*caring* programs

Getting or staying healthy or learning how to manage a chronic illness takes a partner – a health*caring* partner – and that's Blue Cross Blue Shield of Michigan. Our personal support programs help you understand the advice and treatment you receive from your physician so you can make the best and most informed health care choices.

All of our programs are **voluntary and strictly confidential** and you can find them at **www.bcbs.com.**

Healthcare Advisor™

Healthcare Advisor is an online resource that helps you:

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

Coverage Advisor™

Coverage Advisor™ is designed to help you, as the key decision maker for your health care coverage, identify the type of health plan that best fits your lifestyle.

Through Coverage Advisor you can calculate your health care costs before they occur simply by following these three steps:

1. Create a profile for yourself and those covered under your health plan.
2. Estimate your health care use by answering a few questions about medical services expected during the next 12 months.

3. Input basic information about the different plans that you're considering.

The Coverage Advisor calculates your estimated out-of-pocket costs under each selected plan. The format is easy to follow and can be completed within minutes.

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 **1-800-775-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 health*caring* 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
- **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 on information of 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 pinpoint 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 lifestyles 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 – From health articles to calculator tools BlueHealthConnection's interactive tools help you participate with your physician in planning your health goals.

Calculator tools – BlueHealthConnection has interactive tools that can help you learn about general health information and how such factors as body mass affect you and your families' 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

Money-saving programs

Showing your Blues ID card can save you money through these programs:

BlueSafe℠

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

Naturally Blue℠

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

Weight Watchers®

Our partnership with Weight Watchers gives you more than a 25 percent discount off the registration fee and initial 12- or 13-week enrollment.

For further information on these programs, visit our Web site at www.bcbsm.com and click on Helping Members Save Money.

Choosing your provider

How much you pay for services you receive depends on whether you use a network or out-of-network network provider. We'll explain the difference below.

What is a network provider?

A network (panel) provider is a physician, hospital, or other health care specialist who provides services through our PPO network. PPO network providers have signed agreements with BCBSM to accept our approved amount as payment in full for services covered under your health care plan. Using PPO network providers limits your out-of-pocket costs for covered services to any in-network deductible and co-pays **that may be** required by your plan.

> **Special note for parents of students:** Dependents attending school away from home still need to choose a PPO physician to remain in-network. (See the section on BlueCard.)

What is an out-of-network provider?

An out-of-network (non-panel) provider is a physician, hospital or other health care specialist who has not signed an agreement to provide services through our PPO network. Your health care plan generally has higher out-of-pocket deductible and co-pays for services received outside the PPO network.

> **Important:** Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible and co-payment as payment-in-full for covered services.
>
> Nonparticipating providers have not signed an agreement and **can bill** you for any differences between their charges and our approved amount.

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

Here is an example of the type of out-of-pocket costs you may incur when you use a PPO network provider versus an out-of-network provider.

You choose a PPO network provider	You choose an out-of-network provider	
	Participating provider	**Nonparticipating provider**
■ Least out-of-pocket cost to you*: – A fixed dollar co-pay for selected office visits – Many preventive care benefits are covered at no cost to you ■ **No** balance billings ■ **No** claim forms to file	■ More out-of-pocket costs to you: – An annual deductible – Percent co-pay for all services, except emergency visits – Some services such as preventive care may not be covered out-of-network ■ **No** balance billings ■ **No** claim forms to file	■ Most out-of-pocket costs to you: – An annual deductible – Percent co-pay for all services, except emergency visits – Some services such as preventive care may not be covered out-of-network ■ Possible balance billings ■ Claim forms to file

* Your health care plan **may also require** in-network deductibles and percent co-pays. Please refer to the benefit chart for your health care plan requirements.

How providers are paid

Under your health care program, the payment allowed for covered services is called the Blue Cross Blue Shield of Michigan approved amount. Our approved amount is the lower of the provider's billed charge or the BCBSM-maximum payment level for the covered service. Any deductible or co-pays required by your health care plan **are subtracted from the approved amount** before we make our payment.

PPO network providers – BCBSM sends payment directly to network providers. Because of their signed agreement with BCBSM, network providers will accept this payment as payment in full for covered services. You are only responsible for any in-network deductible or co-pays **that may be** required by your health care plan.

Out-of-network providers – Unless you have a referral from a PPO network provider, your care is considered out-of-network. When choosing to go out-of-network, it is important to verify if the service is covered, **because not all services may be covered** out-of-network.

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

- **Participating providers** – BCBSM sends payment directly to participating providers. Because of their signed agreement with BCBSM, participating providers will accept this payment as payment in full for covered services. You are only responsible for any out-of-network deductible or co-pays required by your health plan.

- **Nonparticipating physicians and other professional providers** – BCBSM sends payment directly to you and it is your responsibility to pay the provider. Because this payment may be less than the provider's charges, you may also have to pay the provider the difference between our payment and his/her charge. This would be **in addition** to any out-of-network deductible or co-pays required by your health plan.

- **Nonparticipating hospitals, facilities and alternatives to hospital care providers** – BCBSM's payment for services received at a nonparticipating hospital is very limited and covers only those services required to **treat an accidental injury or medical emergency.** This means that you will need to pay most of the charges yourself and your bill could be substantial. **Please refer to your health care certificate for a complete explanation of your coverage when services are provided by a nonparticipating hospital or facility.**

BlueCard® program

When traveling **outside of Michigan**, your coverage travels with you. Through the BCBSM BlueCard program, you have access to network and participating providers throughout the U.S. and around the world.

And like network and participating providers in Michigan, you won't have to fill out any claim forms or pay up front for the cost of the service unless it is an out-of-pocket cost, such as a deductible or co-pay or a non-covered service.

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

1. In an emergency, go directly to the nearest hospital.

2. Call 1-800-810-BLUE (2583) or use the BlueCard Doctor and Hospital finder Web site at www.bcbs.com. You will be given the names and addresses of nearby doctors and hospitals.

3. When you arrive at the network or participating provider's office or hospital, present your ID card. The doctor or hospital will recognize the suitcase logo and that you are receiving services under the BlueCard program. This means they will submit any claims forms and only bill you for any deductible or co-pay that may be required by your health care plan.

Care out of the U.S.

With our BlueCard program, your coverage also travels with you to foreign countries. When you need care outside of the United States, follow these five steps:

1. Check your certificate to make sure your international benefits are the same outside of the United States

2. If you need to find a provider, call the **BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177**, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

3. **In an emergency**, go directly to the nearest doctor or hospital, then call the BlueCard Worldwide Service Center if you are hospitalized. For **non-emergency** inpatient medical care, you must call the BlueCard Worldwide Service Center to arrange access to a BlueCard Worldwide hospital. To locate a doctor or hospital, or need medical assistance services

4. If you need to be hospitalized, call your Blue Plan for **pre-certification or pre-authorization**. You can find the phone number on your Blue Plan ID card.

   Note: this number is different from the phone number listed above.

5. If the BlueCard Worldwide Service Center arranged your hospitalization, the hospital will file the claim for you; you will need to pay the hospital for the deductible or co-pay expenses you normally pay.

6. For outpatient and doctor care or inpatient care **not arranged** through the BlueCard Worldwide Service Center, you will need to pay the provider and submit a claim form with original bills to BCBSM. Try to get all itemized receipts, preferably in English. We will pay the approved amount for covered services at the rate of exchange in effect on the date of service, minus any deductible or co-pay that may be required by your plan.

Claims information

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

Filing a claim

If you receive services from a nonparticipating or non-network provider first ask them if they will bill BCBSM for the services. Most providers, even those who do not participate with BCBSM, will submit claims to their patient's insurance companies when asked.

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

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

   1. Name and address of provider
   2. Full name of patient

3. Date of service
4. Provider's charge
5. Diagnosis and type of service

*The provider must also indicate a federal tax ID number.

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

2. Make a copy of all items for your files and send the originals to BCBSM at the address listed in Where to Write Us. It is important that you file claims promptly because most services have a claims filing limitation.

3. When payment is made, it will be directly to the subscriber.

Explanation of Benefit Payments (EOBP)

After we process claims for services you receive, we send you an Explanation of Benefit Payment (EOBP). **The EOBP is not a bill**. It is a statement that helps you understand how your benefits were paid. At the top of the EOBP you'll find Blue Cross Blue Shield Customer Service numbers and an address to use for inquiries.

Receive your EOBP electronically

From the secured area of our web site, you can view, save or print your EOB statements. Visit www.bcbsm.com to sign up for this feature.

About your EOBP

Briefly your Explanation of Benefit Payments tell you:

- The person who received the services
- The date services were provided ("claims processed from…to…").
- **"Summary of Balances"** includes the provider(s) of the services, detail about charges and payments, including the amount saved by using Network providers.
- **"Summary of Deductibles and Co-payments"** provides your deductible and co-payment requirements as well a total of all deductibles and co-payments paid to date.
- **"Helpful Information"** includes messages and reminders.

- **"Detail on Services"** summarizes the BCBSM payment and shows your balance.

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

The following page is an example of our EOBP form.

Coordination of Benefits (COB)

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

How COB works

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

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

- Secondary plan is responsible for paying **after** your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by the carriers.

Filing secondary COB claims

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

Updating COB information is your responsibility

Claims processing delays can be avoided if you keep your COB information updated. View your current COB information at www.bcbsm.com.

If you need to change the information we have on record, notify the Fund Office immediately. We may also periodically ask you to update your COB information through a Letter of Inquiry. Please help BCBSM service you better by quickly responding to this request.

Women's Health and Cancer Rights Act

The Federal Law requires that all health care plans that provide medical and surgical benefits for mastectomies provide participants and beneficiaries receiving mastectomy benefits and who elect mastectomy related breast reconstruction with coverage for the following:

- **Reconstruction of the breast on which the mastectomy has been performed.**
- **Surgery and reconstruction of the other breast to produce a sym-metrical appearance; and**
- **Prostheses and physical complications of all stages of mastectomy including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.**

The Fund has provided coverage for mastectomies for a number of years. As part of this coverage, the Plan also covered the procedures necessary to effect reconstruction of the breast on which the mastectomy was performed, as well as the cost of prostheses and physical complications of all stages of mastectomy, including lymphedemas, as recommended by the attending physician of any patient receiving Plan benefits in connection with the mastectomy and in consultation with the patient. The Plan also covers any surgery and reconstruction of the other breast to achieve a symmetrical appearance.

MOTHERS AND NEWBORNS HEALTH PROTECTION ACT

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

Subrogation

Your contract with Blue Cross Blue Shield of Michigan includes a provision called "subrogation." If you file a lawsuit or an insurance claim, or if there is a settlement, subrogation allows Blue Cross Blue Shield of Michigan to hold a party that caused an injury or condition to be responsible for payment of the medical expenses related to the injury.

For example, a Blues member is injured in a store, or other commercial property, due to negligence on the part of the store or property. BCBSM pays for the services to the injured person, as required by their health care contract. Later the member sues the store. The Blues' Subrogation Unit would attempt to recover the money paid for medical services in that lawsuit.

The types of cases we pursue generally fall into the following categories.

- Worker's Compensation
- Personal injury
- Medical malpractice

Please remember if you hire an attorney to represent you in such a situation, you should always have your attorney contact Blue Cross Blue Shield of Michigan at (517) 322-8177.

Confidential Information

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

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

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

Your right to file a grievance or appeal

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to one of our Customer Service Representatives. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing a grievance procedure, including a managerial-level conference, if you believe that we have violated **Section 402 or 403 ob Public Act 350**. You will find the specific provisions of those two parts of the act at the end of this section.

A. Standard grievance procedure

Under the standard grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time that you are permitted to take to file your grievance, and for a period of up to 10 days if we have not received information we have requested from a health care provider, for example your doctor or hospital. The standard grievance procedure is as follows.

1. You or your authorized representative must sendBCBSMa written statement explaining why you disagree with our determination on your request for benefits or payment.

   Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.

   We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.

2. If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing. Mail your request to:

Conference Coordination Unit
Blue Cross Blue Shield of Michigan
P.O. Box 2459
Detroit, MII 48231-2459

You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit or at a local customer service center. Our written proposed resolution will be our final determination regarding your grievance.

In addition to the information found above, you should also know:

a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard grievance procedure.

b. Although we have 35 days within which to give you our final determination, you have the right to allow BCBSM additional time if you wish.

c. You may obtain copies of information relating to our denial, reduction, or termination of coverage for a health care service for a reasonable copying charge.

B. Expedited grievance procedure

If a physician substantiates, orally or in writing, that adhering to the timeframe for the standard internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. You may file a request for an expedited grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service or if you believe we have failed to respond timely to a request for benefits or payment.

The procedure is as follows:

You may submit your expedited grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone at **(313) 225-6800**.

We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

In addition to the information found above, you should also know:

a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited grievance procedure.

b. If our decision is communicated to your orally, we must provide you with written confirmation within 2 business days.

Sections 402 and 403 of Public Act 350

What we may not do

The sections below provide the exact language in the law.

Section 402(1) provides that we may not do any of the following:

- Misrepresent pertinent facts or certificate provisions relating to coverage
- Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.
- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.
- Refuse to pay claims without conducting a reasonable investigation based upon the available information.
- Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

- Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear.
- Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.
- Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage.
- Make known to the member a policy of appealing from administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim.
- Attempt to settle a claim on the basis of an application which was altered without notice to, knowledge or consent of, the subscriber under whose certificate the claim is being made.
- Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.
- Fail to promptly provide a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement.
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate.

Section 402(2) provides that there are certain things that we cannot do in order to induce you to contract with BCBSM for the provision of health care benefits, or to induce you to lapse, forfeit or surrender a certificate issued by BCBSM or to induce you to secure or terminate coverage with another insurer, health maintenance organization or other person.

The things we cannot do under this section:

- Issue or deliver to a person, money or other valuable consideration.
- Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.
- Offer to give or pay, directly or indirectly, a rebate or part of a premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.
- Make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits there under, or the true nature thereof.
- Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of

the corporation and another health care corporation, health maintenance organization or other person.

What we must do

Section 403 provides that we must, on a timely basis, pay to you or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to you will bear simple interest from a date 60 days after we have received a satisfactory claim form at a rate of 12 percent interest per year. The interest will be paid in addition to the claim at the time of payment of the claim.

We must specify in writing the materials which constitute a satisfactory claim form no later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form will be considered to be paid on a timely basis if paid within 60 days after we receive the claim form.