

**MICHIGAN GLASS & GLAZING INDUSTRY
WELFARE INSURANCE PLAN
SUMMARY PLAN DESCRIPTION**



May 2007

MICHIGAN GLASS & GLAZING INDUSTRY WELFARE INSURANCE PLAN

SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE

This summary plan description booklet describes the Plan on May 1, 2007. If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

One word of caution: NO ONE HAS THE AUTHORITY TO SPEAK FOR THE TRUSTEES IN EXPLAINING THE ELIGIBILITY RULES OR BENEFITS OF THE FUND, EXCEPT THE FULL BOARD OF TRUSTEES OR THE FUND'S ADMINISTRATIVE MANAGER TO WHOM SUCH AUTHORITY HAS BEEN DELEGATED.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

MICHIGAN GLASS & GLAZING INDUSTRY WELFARE INSURANCE PLAN

IMPORTANT ADDRESSES AND PHONE NUMBERS

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The Board of Trustees is the legal Plan Administrator.

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**AGENT DESIGNATED FOR SERVICE OF
LEGAL PROCESS**

Patricia J. Tarini or Ann E. Neydon

1000 Farmer

Detroit, Michigan 48226

Legal process may also be served on any Trustee or the Plan Administrator.

**BLUE CROSS/BLUE SHIELD OF MICHIGAN (BCBSM)
(For all BCBSM matters)**

BCBSM Customer Service

Area code 313 - (313) 225-8100

Outside area code 313 - (800) 637-2227

Hearing and speech impaired customers:

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

Area codes 231 and 616 - (616) 285-2114 or (800) 867-8980

When writing:

Blue Cross/Blue Shield of Michigan

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Website:

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INTRODUCTION

To All Participants and Dependents:

We are pleased to provide you with this summary description of the **MICHIGAN GLASS & GLAZING INDUSTRY WELFARE INSURANCE PLAN**.

As you read through this booklet, keep in mind that it is an effort to summarize, simply, the principal provisions of the formal Plan. It is not intended to cover every detail of the Plan or every situation which might occur. We have tried to make the summary accurate and complete, but it is not a substitute for the Plan itself. If there is any conflict or difference between the summary in this booklet and the Plan, the Plan will control.

Since the last booklet was published, many changes have been made in the Plan. These changes have previously been communicated to you in the form of notices and announcements. This new summary incorporates all of those changes which have been made and which are still in effect. Accordingly, this summary cancels, replaces, and supersedes all prior summaries, booklets and changes which have previously been communicated to you.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits it provides for you and your family, and how to obtain those benefits.

As Trustees, we pledge to maintain the best and most equitable program we can within our available resources. We hope the benefits available through the Fund will be of significant help to you and your family.

Board of Trustees

Keith R. Shannon	Greg Olano
Michael D. Clem, Sr.	Mitchell Shammass
George LeGree	Jon Krebs
Kurt Kennedy	Steven Emmenecker

May 2007

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

GENERAL INFORMATION

The Michigan Glass & Glazing Industry Welfare Insurance Fund was created through collective bargaining. It is sponsored and administered by a board of eight Trustees. Four of the Trustees are Union Trustees, designated by Glaziers, Architectural Metal and Glassworkers, Local Union No. 357 and Painters District Council No. 22 (collectively, the "Union"), and four of the Trustees are Employer Trustees appointed by Glazing Contractors Association, Inc. (the "Association"). The Board of Trustees is the legal Plan Administrator and it has hired the firm of BeneSys, Inc. as Administrative Manager to operate the program on a day-to-day basis.

The Fund has been assigned an Employer Identification Number by the Internal Revenue Service. It is 38-6058023. The Plan Number is 001.

The Fund operates on a December 1 through November 30 fiscal year. This fiscal year is used for Fund accounting and for filing annual reports required by the Internal Revenue Service and the United States Department of Labor. The benefit year or claim determination period for benefits is January 1 through December 31.

The Insurance Plan established by the Trustees is subject to the Employee Retirement Income Security Act of 1974, as amended, usually referred to as ERISA.

The Plan is funded through the Trust Fund, which receives contributions made by employers at rates specified in collective bargaining agreements between the Association and the Union. Participants may make payments to the Fund under certain circumstances described below in order to continue eligibility. Any participant, surviving spouse, or beneficiary may receive, upon written request to the Fund Office, information about whether a particular employer is contributing to the Fund and, if so, the employer's address.

Medical, hospital, surgical and dental benefits are insured and provided through insurance contracts with Blue Cross/Blue Shield of Michigan (group number 55886). Life Insurance and Accidental Death and Disability Insurance are insured through the Union Labor Life Insurance Company (policy numbers G-3011 and C-4299). All other benefits, including prescription drug benefits, are paid directly from the Trust and are "self-funded".

As circumstances require, the Board of Trustees may change the eligibility rules and/or benefit provisions of the Insurance Fund's Plan at any time. The benefits provided by the Fund are limited to the assets of the Fund which are available to pay for such benefits. *No participant, dependent or retiree has a vested right to any benefit provided by the Fund, now or at any time in the future.*

If you have any questions about the Insurance Fund's Plan, you should contact the Fund Office or the Board of Trustees.

Your rights under federal law as a participant in this program are the same as they are in respect to other fringe benefit programs. You are urged to read the ERISA RIGHTS section of this booklet.

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TRUSTEE AUTHORITY

The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules and other provisions of the Plan at any time. However, the Board of Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable while they are in effect. The right to change or eliminate any and all aspects of benefits provided for retirees and their dependents is a right specifically reserved to the Board of Trustees.

Notices of any changes or deletions of the information in this book will be provided to each participant within the time required by any applicable regulations, but some changes may take effect before you are notified of a change. Before incurring any non-emergency expense, you should contact the Fund Office to confirm your current entitlement to coverage.

This book is intended to give you an accurate summary of the benefits and provisions of the Fund's Plan. It does not describe Plan changes that occurred after the book was printed. The Plan and the Agreement and Declaration of Trust, which you can read at the Fund Office or other specified locations, contain a detailed description of the rules, regulations, benefits and provisions of the Fund. If any discrepancy exists between this book and the Plan documents (including the insurance contracts entered into by the Fund), the provisions of the Plan documents will govern.

Only the full Board of Trustees is authorized to interpret the Plan and the benefits described in this book, or BCBSM to the extent such authority has been granted. The interpretation of the Board of Trustees, or BCBSM to the extent such authority has been granted, is final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. If a decision of the Board of Trustees and/or BCBSM, as applicable, is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from the Union, the Association, or an employer has the authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

If you have questions about your eligibility or a claim, contact the Fund Office. Matters that are not clear, or which need interpretation, will be referred to the Board of Trustees.

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DOING YOUR PART

As a participant with the Fund, you have certain responsibilities in order to protect your eligibility and receive your benefits.

Read this book. You and your spouse should take the time to read this benefit book and familiarize yourselves with the eligibility and benefit rules.

Keep the Fund Office informed about you. One of your most important responsibilities is to make certain that the Fund Office always has current and accurate information about you and your dependents. This information is necessary in order for you to get notices, cards, verification of benefits, updates, for beneficiary designations, and numerous other reasons important to your coverage.

- You must complete a Vital Information Enrollment Form immediately and return it to the Fund Office if you are a new participant.
- Whenever any of the information on that Form changes, you must notify the Fund Office **immediately**. Important changes include any change in your address, any change in your family, such as marriage, birth, adoption, death, divorce, legal separation or a child losing dependent status, and any change in the beneficiary designation for purposes of the Fund's Life Insurance Benefits. Failure to notify the Fund Office of these matters in a timely manner can result in permanent loss of COBRA rights, missed notices from the Fund Office, and responsibility for medical expenses.
- Other important things you should tell the Fund Office are:
 - If you are unable to work due to accident or illness;
 - If your disability has ended;
 - If you have applied for family or medical leave from your employer;
 - If you have entered the military;
 - If a court has entered a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund; and
 - If you or your dependent(s) are eligible for or have received benefits under another health care plan, insurance contract, program or statute.

Follow the proper procedures for receiving benefits, filing claims and submitting appeals. Review the information in this book for information on claims processing. When in doubt, before incurring any non-emergency expense, ask the Fund Office about claims processing and benefits.

Carry your card. You should have a BCBSM Identification Card and a Caremark prescription card. Be certain to carry these, and show them whenever you receive medical care or get a prescription.

Keep copies of all bills and EOBs. It is important that you keep any bills and Explanations of Benefits ("EOBs") that you receive. These can be valuable in any claim or appeal you may make, and, possibly, as your only record of benefits and care you have received.

Keep notices you receive from the Fund. After the publication of this book, you will receive notices of benefit changes as they occur. You should keep those together with this book in order for you to have a complete record of the Plan's communications to you regarding your benefits.

Keep track of the payments you submit to the Fund on your behalf. Your eligibility depends on it.

Identify yourself. When you write to the Fund Office, please be sure to include your name, the last four digits of your Social Security number or the alternative identification number assigned to you by the Fund Office and your trade in your letter. If you call, please be sure to have your Social Security number or the alternative identification number handy.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

Notify the Fund Office when you or one of your dependents becomes eligible for Social Security benefits and/or Medicare coverage. You must sign up for Medicare Part A and B (but **not** Medicare Part D prescription coverage) and send a copy of the Social Security Award letter and/or the Medicare Card to the Fund Office immediately.

Protect your and your dependents' COBRA rights. Your surviving, separated or divorced spouse, and/or your children who no longer qualify as eligible dependents **must** notify the Fund Office **within 60 days** of the date on which the event occurred that resulted in their loss of eligibility that they want to continue their coverage under the Fund through self-payments under COBRA. If the Fund does not receive notice within the 60 day period, they will **lose** their right to continue coverage through self-payments under COBRA.

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ADMINISTRATIVE RESPONSIBILITIES

The Plan Administrator, as a legal matter, is the Fund's Board of Trustees. However, the Board of Trustees has divided the day-to-day operations of the Fund into three areas of responsibility, and has delegated them to the Fund Office, BCBSM or Caremark.

Fund Office Functions

The Fund Office is responsible for the following:

- Day-to-day details of running the Fund, including financial and record-keeping functions
- All matters pertaining to eligibility
- Self-payments, including actives, retirees, surviving spouse and COBRA
- Claims for the following benefits:
 - Life Insurance Benefits
 - Accidental Death and Dismemberment Benefits
 - Weekly Disability Benefits
 - Vision Expense Benefits
- Reviewing and presenting appeals to the Board of Trustees

Blue Cross/Blue Shield of Michigan Functions

The Fund has a contract with Blue Cross/Blue Shield of Michigan to insure all medical, surgical, hospital and dental expense claims in accordance with the Blue Cross/Blue Shield of Michigan schedule of benefits.

Caremark Functions

The Fund has a contract with Caremark to administer all outpatient prescription drug benefits.

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ELIGIBILITY AND COVERAGE

INITIAL ELIGIBILITY REQUIREMENTS

You will be initially eligible for benefits on the first day of the month after you have been credited with 140 hours of work and employer contributions in two (2) consecutive calendar months or less and you will remain eligible based on those hours of work and employer contributions for two months.

Example: If you work a total of at least 140 hours (for which all employer contributions have been received by the Fund) in August and September, you become eligible for benefits on November 1 and you will remain eligible based on those hours of work and employer contributions for the months of November and December.

When you become eligible, you will be furnished with a Vital Information Enrollment Form to report all of your eligible dependents. This form should be completed and returned to the Fund Office as quickly as possible with copies of applicable birth and marriage certificates and, in cases of divorce, court orders. Be certain to report all changes (i.e., additions and deletions) among your dependents to the Fund Office immediately.

CONTINUING ELIGIBILITY REQUIREMENTS

1. Continuation by Working

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits for the “eligibility month” that corresponds to the month in which you worked and have been credited with 140 hours of work and employer contributions as follows:

Hours worked during the month below . . . _____	will determine eligibility for the <u>Eligibility Month of . . .</u>
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

2. Continuation Without Working

If your eligibility would otherwise terminate due to insufficient hours of work and/or employer contributions received by the Fund, you may elect to maintain eligibility as a participant for a **maximum of six (6) months** by drawing on your Hourly Reserve Bank and/or making self-payments. (Participants who were not eligible based on work covered by the Union’s collective bargaining agreement and participants who are employed by the Union cannot draw on an Hourly Reserve Bank and/or make self-payments to maintain eligibility.)

a. Continuation by Drawing on the Hourly Reserve Bank

An Hourly Reserve Bank is established for you by the Fund Office. For each calendar month in which the Fund receives employer contributions in excess of 140 hours based on your hours of work, the hours in

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excess of 140 hours are “deposited” in your Hourly Reserve Bank. The maximum number of hours you can have in your Hourly Reserve Bank is 420 hours.

Then, when your eligibility would otherwise terminate due to insufficient hours of work and/or employer contributions received by the Fund for a month, the number of hours needed to equal 140 hours for that month will be withdrawn from your Hourly Reserve Bank to continue your eligibility.

When the hours (with employer contributions) that you have worked during a calendar month plus all the hours left in your Hourly Reserve Bank are less than 140 hours, and you wish to maintain eligibility, you may make a self-payment for the difference in hours needed to maintain your eligibility for that month (see below).

Your Hourly Reserve Bank remains available for up to six months after your eligibility terminates. However, after six months of ineligibility, any remaining hours in an Hourly Reserve Bank are cancelled.

You cannot receive Weekly Disability Benefits while maintaining your eligibility by using your Hourly Reserve Bank.

b. Continuation by Self-Payments

If you cannot fulfill the 140 hour requirement for continuing eligibility by any combination of working and drawing on your Hourly Reserve Bank, you may maintain eligibility by making self-payments for the balance of the six-month period for continuing eligibility without working. The self-payment rate is the difference between the actual hours worked and those required for eligibility multiplied by the current employer contribution rate set forth in the collective bargaining agreement. That is, the amount of the self-payment you will have to pay to continue your eligibility is the number of hours (with employer contributions) you are short for the month, multiplied by the current employer contribution rate.

If, at any time during the six-month period in which you are eligible to make self-payments, you elect not to do so and, as a result, your eligibility is terminated, you shall not again be eligible to make self-payments until such time as you meet the requirements for reinstatement of eligibility or you re-establish eligibility.

The Fund Office shall make a reasonable effort to notify you that you have the option to elect to make self-payments when your eligibility for benefits is about to terminate. If you fail to make a self-payment when due (or if you fail to reinstate through hours of work and employer contributions), your coverage will be terminated. Self-payments are due on the 25th of the month before the eligibility month. For example, self-payment for eligible for benefits for the month of October is due September 25th. You may be reinstated only by satisfying the initial eligibility requirements. **It is important that you keep the Fund Office notified of your current mailing address.**

You cannot receive Weekly Disability Benefits while maintaining your eligibility by self-payment.

3. Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you or they have other health insurance coverage, you may subsequently enroll yourself or your dependents in this Plan provided that you request enrollment within **30 days** after such other coverage ends. Proof of the other health care coverage and its termination date will be required for re-enrollment.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll such newly acquired dependent for coverage provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. Appropriate proof will be required for enrollment.

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DISABILITY ELIGIBILITY

If you become disabled when you are eligible for benefits, your eligibility will be continued for the balance of the month in which you became disabled and thereafter for up to a total 18 consecutive months without cost to you. For this purpose, you are disabled if you are unemployable as a result of an illness or injury either on or off the job, and such disability continues for one week or more.

In order to qualify for this eligibility, you must be under the treatment of a physician, file a claim form and submit satisfactory written medical evidence of your disability to the Fund Office. Upon approval of your application, your disability eligibility will be retroactive to the date your disability commenced.

You may continue coverage at no cost for the duration of your disability, up to the 18 month maximum (which commences with the date of onset of your disability), provided proof of disability is presented to the Fund Office within 30 days of the onset of disability. After that 18-month period, you may continue coverage through use of the balance of the hours in your Hourly Reserve Bank and through self-payments. However, the total of your disability eligibility period and the period in which your eligibility is maintained through the Hourly Reserve Bank and self-payment cannot exceed 24 consecutive months.

TERMINATION OF ELIGIBILITY

If you have not worked, if your Hourly Reserve Bank has fallen below 140 hours, and if you either failed to make self-payments or exhausted the six-month period for eligibility without working, your eligibility will terminate on the last day of the last month for which you had maintained eligibility.

REINSTATEMENT OF ELIGIBILITY

If your eligibility has terminated, you will be eligible for benefits again on the first day of the third month after you have been credited with 140 hours of work and employer contributions in two (2) consecutive calendar months or less and you will remain eligible based on those hours of work and employer contributions for one month. You may use hours remaining in your Hourly Reserve Bank toward reinstatement. However, after six (6) months of ineligibility, any remaining hours in your Hourly Reserve Bank are cancelled.

Example: If your eligibility ends on April 30 and you then work 140 hours in September, you will again become eligible for benefits on December 1 and you will remain eligible based on those hours of work and employer contributions through the month of December.

RECIPROCITY

The Trustees have entered into reciprocity agreements with other insurance and health care funds covering glaziers and glassworkers working in several locals around the country. Under these reciprocity agreements, employer contributions made on your behalf may be transferred from one fund to another upon your written request and authorization. Transferring contributions may enable you to meet the continuing eligibility requirements of this Fund or another fund. If you work in another jurisdiction and employer contributions are made to another fund on your behalf, you should inquire as to whether such contributions can be transferred to this Fund under a reciprocity agreement.

Because contribution rates vary between funds, it is possible that even though the hours you work in another jurisdiction would be sufficient for you to continue eligibility under this Fund, you may be required to pay the monetary difference between the employer contributions paid to the other fund at its lower employer contribution rate and this Fund's employer contribution rate in order to remain eligible.

You should contact the Fund Office to find out whether there is a reciprocity agreement between this Fund and another fund and, if there is, sign the necessary request form to have employer contributions transferred.

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ELIGIBILITY OF DEPENDENTS

1. Eligibility of Spouses and Children

Generally, your dependents are eligible anytime you are eligible for benefits. The only exceptions are (1) when your dependent no longer meets the Plan's definition of dependent, (2) when your dependent enters the armed forces of any country, (3) when your dependent becomes eligible for coverage as a participant in his/her own right, (4) when your dependent child marries, (5) when continuing coverage under COBRA is not elected by or for your dependents, or (6) when dependent coverage is eliminated from the Plan by the Board of Trustees.

Dependents are **never** eligible for Life Insurance Benefits, Accidental Death and Dismemberment Benefits or Weekly Disability Benefits. Dependent children are **never** eligible for pregnancy benefits.

A. Eligibility of Spouses and Children Under Age 19

The dependents which can be included in your coverage are your lawful spouse and any of your or your spouse's unmarried natural, step or adopted children until they reach the end of the calendar month in which they reach the age of 19 so long as those children are financially dependent on you and either

- living with you in a parent-child relationship, or
- if not living with you in such a relationship, legally dependent upon you pursuant to a proper court decree or operation of law.

However, with regard to an unmarried child who has reached the end of the calendar year in which the child turned 18 years old, the child must be receiving more than one-half of his/her support from you, unless the child is a full-time student, in which case the child must be receiving more than one-half of his/her support from you or from his/her custodial parent and either have the same place of abode as you for more than one-half of the calendar year or be claimed as a dependent on your taxes.

Birth certificates and marriage certificates are required to establish proof of eligibility as a dependent. If you were never married to the mother of the dependent child you claim, you must provide proof of paternity, such as a duly registered birth certificate naming you as the father, an order of filiation, an adoption order, or other order of the court such as a qualified medical child support order. In the event that proper proof is not filed and a claim is received, the Fund Office is required to request and obtain such proof before the claim can be processed.

Note Regarding Qualified Medical Child Support Orders: Under federal law, the Plan must recognize qualified medical child support orders (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order which recognizes the right of an alternate recipient (child) to receive benefits under the Plan. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to children of participants. A QMCSO is usually issued in a divorce where the participant is ordered by the court to continue to provide medical support for the children where the children are not residing with the participant. The Fund Office or legal counsel for the Fund will determine whether a document is a QMCSO. If the document is determined to be a QMCSO, the Fund will notify the eligible employee or retiree and the possible alternate recipient (or custodial parent or issuing agency, as appropriate). If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination.

Coverage for the stepchildren of participants is **not** automatic. If you wish to have one or more of your stepchildren covered as your dependent, you must establish that each stepchild is your legal dependent and that no other individual (such as the stepchild's biological parent other than your spouse) is responsible for the child's health care coverage. The Fund Office may require you to provide copies of any divorce documents that your stepchild's parents have in the course of determining responsibility for a stepchild's health care coverage. If another person (such as the stepchild's biological parent other than your spouse) is legally responsible for providing health care coverage for your stepchild, the Fund will not provide such

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coverage. In this regard, you should also review the provisions on Coordination of Benefits on page 79 of this booklet.

B. Eligibility for Dependent Children Age 19 and Older

Your or your spouse's unmarried natural, step or adopted children may be included in your coverage after the end of the calendar month in which they reach the age of 19 if they are either full-time students or disabled.

Eligibility for Full-Time Students: An unmarried dependent child may continue coverage under the Plan after the end of the calendar month in which he reached the age of 19, but prior to reaching age 25, if the child is attending college or university as a full-time student (enrolled in not less than 12 credit hours per academic semester), and meets the following income tests:

- If the child is age 19 through age 23, the child must **not** be providing over half of his or her own support and must either have the same place of abode as you for more than one-half of the year or be listed as a dependent on your tax forms
- If the child is age 24, the child must be receiving over half of his or her support from you

The Board of Trustees may, in its sole and exclusive discretion, waive the 12 credit hours per academic semester requirement where it is established to its satisfaction that the student is engaged in other non-credited educational activities or under other special circumstances, such as where the student is incapable without hardship of maintaining 12 credit hours per academic semester.

Eligibility for Disabled Children: An unmarried dependent child may continue coverage under the Plan after the end of the calendar month in which he reached the age of 19, but prior to reaching age 25, if he becomes totally and permanently disabled from either a physical or mental condition prior to the end of the calendar month in which he attains the age of 19, and his eligibility shall continue as long as such permanent disability exists.

2. Enrollment of Dependent Spouses and Children

You may enroll your dependents at the time of your initial eligibility under the Plan.

If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, after your initial eligibility, you may enroll that new dependent for coverage under the Plan within **30 days** of the date that person becomes your dependent by giving written notice to the Fund Office and including copies of the birth certificate or other proof of parentage for children such as an order of filiation or adoption order, marriage certificates and divorce judgments establishing responsibility for health care for stepchild(ren). Eligibility for new dependents begins no sooner than notice is received, so it is to your benefit to provide notice to the Fund Office as quickly as possible.

If you do not enroll one or more of your eligible dependent(s) for coverage at the time of your initial eligibility, or the acquisition of the dependent if later, due to such dependent(s)'s coverage under another health plan, you may enroll such eligible dependent(s) upon the subsequent loss of that other coverage provided that the enrollment is made within 30 days of the loss of the other coverage.

Enrollment for Dependent Children Age 19 and Older: Enrollment for dependent children who are age 19 and older is on the first day of the month following the end of the calendar month in which the dependent child attains age 19. However, if a dependent child is covered by another group health plan when his coverage under this Plan would otherwise terminate, he may apply for coverage no later than 30 days after the date on which the dependent child loses such other coverage, provided he still meets all of the requirements for coverage as a dependent child over age 19 and he applies for coverage before his 25th birthday if he is attending a college or university as a full-time student.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

3. Termination of Dependent Eligibility

A. Termination of Coverage for Spouses

A spouse's coverage ends at the end of the month in which a Judgment of Divorce or Judgment of Legal Separation from the participant is entered. It is your obligation to notify the Fund **immediately** upon your divorce or legal separation. **If you delay in providing notice of your divorce or legal separation to the Fund, and the Fund pays benefits on behalf of your ineligible former or separated spouse, you must repay the Fund for any amounts paid by the Fund.** The Fund reserves the right to recover the amount of any benefits paid on behalf of your former or separated spouse from you, from your former or separated spouse, and from both of you, through offsetting the amount paid on behalf of your former or separated spouse from any future benefits payable to you, through litigation, through termination of your participation in the Fund and through any other lawful means.

Any coverage for a former or separate spouse after the end of the month of the date of entry by the court of a judgment of divorce or legal separation is available only under the terms of COBRA continuation coverage. If the Fund Office is not notified of a divorce or legal separation within 60 days of the date of the Judgment is entered by the Court, the Fund has no obligation to, and will not, offer COBRA coverage. See page 16 for details on COBRA continuation coverage.

A spouse's coverage also ends upon entry of the spouse into the armed forces of any country or upon the elimination of spousal coverage under the Plan.

B. Termination of Coverage for Children

Children who qualify as your dependents will be eligible for benefits **until** the earliest of the following dates:

- (1) the end of the calendar month in which the child reaches the age of 19, unless the child satisfies the eligibility requirements for dependent children age 19 and older;
- (2) the date the child marries; or
- (3) the date the child becomes eligible for benefits from the Fund as a result of hours worked and employer contributions received by the Fund on behalf of the child based on covered employment; or
- (4) the date the qualified medical child support order is terminated or amended so as to terminate the Fund's obligation; or
- (5) the date the child no longer meets the definition of dependent; or
- (6) the date the child enters the armed forces of any country; or
- (7) the date dependent child coverage is eliminated from the Plan by the Board of Trustees.

SURVIVOR COVERAGE

If you die when you and your dependents were eligible for benefits under the Plan, your surviving spouse and dependent child or children are entitled to continued coverage without cost to them from the date of your death until your Hourly Reserve Bank, if any, falls below 140 hours. This coverage is an alternative to COBRA continuation coverage.

After your Hourly Reserve Bank, if any, falls below 140 hours, your surviving spouse may continue coverage for herself and your dependent child or children by means of self-payment. If you have no surviving spouse or if she

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does not elect survivor coverage for herself, your dependent children are not eligible for survivor coverage - their coverage may be continued only under the provisions of COBRA continuation coverage.

If a surviving spouse notifies the Fund Office within 30 days of the above date that she is declining this coverage because of other insurance, she may enroll later if she wishes provided she does so within **30 days** of the other insurance terminating (for dependent children, providing also that they continue to meet the Plan's definition of dependent). Proof of the other insurance and its termination date will be required for re-enrollment.

The election of survivor coverage must be made within 30 days after the later of the your date of death or the date your Hourly Reserve Bank, if any, falls below 140 hours. The first payment, which must include the self-payment for the first and second months of coverage, must be made by the election deadline. After your surviving spouse makes her first payment for survivor coverage, she will be required to make monthly payments. Each of these monthly payments is due no later than the 25th of the month before that coverage period. For example, payment for August coverage is due on July 25th.

If the surviving spouse continues to make the required self-payments when due, coverage for the surviving spouse and any dependent children of the deceased active participant (including children of a male deceased active participant born to his surviving spouse within nine months after his death) will continue until, as applicable:

- (1) (for the surviving spouse and children) the surviving spouse remarries; or
- (2) (for the surviving spouse and children) the surviving spouse becomes eligible under another group health care plan; or
- (3) (for each child) the child becomes eligible under another group health care plan; or
- (4) (for each child) the child no longer meets the Plan's definition of a "dependent"; or
- (5) (for the surviving spouse and children) the Plan no longer provides survivor coverage or dependent coverage.

The self-payment rates will be determined by the Trustees from time to time and will vary depending on whether the surviving spouse is covered by Medicare and on whether there are any dependent children. A surviving spouse who is eligible for Medicare will be expected to participate in both Medicare Parts A and B, but not Medicare Part D coverage. The Fund will not pay any expenses which would normally be paid by Medicare Part B incurred on behalf of anybody who is eligible to purchase Part B coverage.

If the surviving spouse does not elect not to maintain coverage under these provisions, then she and your dependent child or children may continue coverage pursuant to and subject to all provision regarding COBRA for 36 months under the terms of COBRA at the monthly COBRA rates then applicable.

RETIREE COVERAGE

1. Eligibility

If you are part of the bargaining unit on the effective date of your retirement under the International Union of Painters and Allied Trades Union and Industry Pension Fund, you are entitled to continue coverage without cost to you from the effective date of your retirement until your Hourly Reserve Bank, if any, falls below 140 hours.

You shall be eligible for retiree coverage after your Hourly Reserve Bank, if any, falls below 140 hours, or your effective date of retirement, whichever is later, **if** you satisfy the following requirements: (1) you are receiving a pension from the International Union of Painters and Allied Trades Union and Industry Pension Fund and (2) you make self-payments at a rate to be established by the Trustees, which may be changed from time to time at their discretion.

You must elect retiree coverage within **30 days** after the later of your effective date of retirement or the date your

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Hourly Reserve Bank, if any, falls below 140 hours. Retiree coverage begins on the later of your effective date of retirement or the first date of the month in which your Hourly Reserve Bank, if any, is below 140 hours, if you elect retiree coverage. The first payment, which must include the self-payment for the first and second months of coverage, must be made by the election deadline. After you make your first payment for retiree coverage, you will be required to make monthly payments. Each of these monthly payments is due no later than the 25th of the month before that coverage period. For example, payment for August coverage is due on July 25th.

The self-payment rates will be determined by the Trustees from time to time and will vary depending on whether the retiree and/or spouse are covered by Medicare and on whether there are any dependent children. A retiree and his spouse who are eligible for Medicare will be expected to participate in both Medicare Parts A and B, but not Medicare Part D coverage. The Fund will not pay any expenses which would normally be paid by Medicare Part B incurred on behalf of anybody who is eligible to purchase Part B coverage.

Failure to Elect Retiree Coverage: If you do not elect retiree coverage (or if you do not timely notify the Fund Office that you are declining enrollment under the delayed enrollment option explained below), your spouse and dependent children are not separately eligible for retiree coverage - their coverage may be continued only under the provisions of COBRA continuation coverage. If you do not elect retiree coverage or COBRA continuation coverage within the applicable periods, you will **not** have the opportunity to elect coverage under the Plan unless you return to covered employment and thereby reinstate or re-establish eligibility.

Delayed Enrollment Option: If you decline enrollment for yourself or your dependents (including your spouse) because you have (or they have) other health care coverage, you may subsequently enroll yourself or your dependents in this Plan provided that you request enrollment within **30 days** after such other coverage ends. Proof of the other health care coverage and its termination date will be required for re-enrollment. If you are declining enrollment for yourself or your dependents, you **must** notify the Fund Office by the election deadline. If you do not notify the Fund Office that you are declining the coverage because you or your dependents have other health care coverage, you and/or your dependents will not be eligible for coverage under the Fund unless you reinstate eligibility under the Plan.

Post-Retirement Marriage/Enrollment of Newly Acquired Dependents: In addition, if you acquire a new dependent after you begin retiree coverage as a result of marriage, birth, adoption, or placement for adoption, you may enroll such newly acquired dependent for coverage provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. Appropriate proof will be required for enrollment.

Spouses With Health Care Coverage Through Their Employment: The Fund does not provide coverage for spouses of retirees who have health care coverage through their own employment. However, if such a spouse loses coverage through her employer's group health plan, she may enroll in this Plan provided that enrollment is requested within **30 days** after the loss of coverage so long as the Fund Office is notified that enrollment was declined due to other coverage within 30 days after retiree coverage begins or marriage to the retiree, if later. Proof of such other health care coverage and its termination date will be required.

2. Termination of Retiree Coverage

If you continue to make the required self-payments when due, your coverage and coverage for your spouse and dependent children will continue until, as applicable:

- (1) (for you, your spouse and your dependents) you return to active employment and/or withdraw from retirement; or
- (2) (for your spouse) you are divorced or legally separated; or
- (3) (for each child) the child no longer meets the Plan's definition of a "dependent"; or
- (4) (for you, your spouse and your dependents) the Fund no longer provides retiree, spouse and/or dependent coverage due to action by the Trustees, which is within their exclusive discretion to do at any time.

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3. Reinstatement in Active Employee Plan - Return to Covered Employment by Retiree

If you re-enter covered employment, you must re-establish eligibility under the initial eligibility provisions of the Plan. You will be allowed to make self-payments until you have satisfied the initial eligibility provisions of the Plan.

FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 provides for up to 12 weeks of unpaid, job protected leave for certain family and medical reasons. You are eligible if you have worked for your employer (1) for at least 12 months and (2) for at least 1,250 hours in the 12 months before the leave starts and if your employer (1) is covered by the Act and (2) has at least 50 employees within 75 miles of where you work.

Whether you are eligible for family or medical leave is determined by your employer, not the Fund.

Both you and your employer are required to notify the Fund if you take a family or medical leave and to provide certain other information as required by the Trustees. The Fund will continue coverage during the period of your family or medical leave, provided your employer makes all required contributions to the Fund at the same rate and in the same amount as if you were continuously employed during the period of your leave and fully complies with all requirements established by the Trustees.

MILITARY SERVICE COVERAGE

If you leave covered employment to serve in the military or other uniformed services (“service”), the Uniformed Services Employment and Reemployment Rights Act (USERRA) requires that the Fund permit you to elect to continue your and your dependents’ eligibility with the Fund (except for Life Insurance, Accidental Death and Dismemberment, and Weekly Disability Benefits).

You should notify the Fund Office as soon as possible that you will be departing for service. If you do not notify the Fund Office before you depart for service and your departure causes you to lose coverage, the Fund Office will generate a notice of COBRA continuation coverage. You (or your family member) must notify the Fund Office that you have departed for service **no later than 60 days** after receiving that notice of COBRA continuation coverage to be eligible for coverage during the period of your service and for special initial eligibility provisions upon your return to work.

If the Fund Office is not notified in the manner above that you have departed for service (or, if it is not feasible to provide notice, then within 30 days from when it becomes feasible to do so), your eligibility for coverage will terminate under the normal eligibility rules and you will have to meet the normal rules for reinstatement of eligibility.

Notice should be provided to the Michigan Glass and Glazing Industry Welfare Insurance Fund P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957, or at 700 Tower Drive, Suite 300, Troy, Michigan 48098.

If you serve fewer than 31 days, no self-payment is required and no reduction of your Hourly Reserve Bank will occur - the Fund is legally required to continue your eligibility without charge if you are in the service for fewer than 31 days without charge or penalty to you.

If you serve for 31 days or more, and you (or your family member on your behalf) have provided notice to the Fund in the required time period, you may continue eligibility by making a self-payment for each month of your service at the Fund’s regular COBRA rates, for up to 24 months, or the period of your service plus 90 days, whichever is lesser. You must elect to continue coverage within time periods applicable to the election of COBRA continuation coverage. You may continue coverage by making monthly self-payments from the beginning date of your service without using the hours in your Hourly Reserve Bank, in which case those hours will be available to you upon your return to work, as explained below, or

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Eligibility Upon Return to Work: If you serve between 31 days and five years, and you (or your family member on your behalf) have provided the Fund Office with notice of your departure for the services as described above, you will not have to meet the normal rules for reinstatement of eligibility if you return to work for a contributing Employer (or register on the out-of-work list) within 90 days of your discharge under honorable conditions.

Your Hourly Reserve Bank will be available to you in full upon your return and will be applied to provide you with eligibility upon your return.

These rules can be complicated. Therefore, please notify the Fund **immediately** when you enter military service and **immediately** upon your discharge to take advantage of your rights under the law.

BLUE CROSS/BLUE SHIELD GROUP CONVERSION COVERAGE

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

- As an alternative to COBRA when you first become eligible for COBRA (described in the next section) **or**
- At the end of your COBRA eligibility period **if** you made all required payments during that period

Your benefits may change under Group Conversion coverage, and the coverage will be limited to your immediate family, but there will be no interruption of coverage provided you pay the initial and subsequent bills. You must be a Michigan resident for at least six months out of each year to be eligible for this type of coverage.

To ensure continuous coverage, you must submit a written request for Group Conversion coverage to BCBSM within 30 days from the date you are no longer eligible for coverage through the Fund **or** within six months before the COBRA coverage ends. For additional information on how to apply for this coverage, contact BCBSM Customer Service at (313) 225-8100 or (800) 637-2227.

COBRA CONTINUATION COVERAGE

Introduction

This section of the Summary Plan Description contains important information about your right to COBRA continuation coverage. **It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

COBRA continuation coverage is a temporary extension of coverage under the Plan. COBRA continuation coverage does not include Life Insurance Benefits, Accidental Death and Dismemberment or Weekly Disability Benefits. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This is only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office and/or get a copy of the Plan Document. The Board of Trustees has delegated the day-to-day responsibilities for the administration of COBRA continuation coverage to the Administrative Manager at the Fund Office. Both the Board of Trustees and the Administrative Manager can be contacted at 700 Tower Drive, Suite 300, Troy, Michigan 48098, (248) 641-4957. Please use the following mailing address for the Board of Trustees and the Administrative Manager: P.O. Box 966, Troy, MI 48099-0966.

COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified

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beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child's parents become divorced or legally separated (but see Qualified Medical Child Support Orders, page 10); or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is loss of coverage due to the end of employment or reduction of hours of employment, the Fund Office will receive that information from your contributing Employer. When the qualifying event is the death of the employee, or the employee's becoming entitled to Medicare (as of this printing, a person covered by the Plan does not lose coverage by becoming eligible for Medicare), the contributing Employer must notify the Fund Office of the qualifying event within 30 days of any of these events.

You Must Give Notice of Some Qualifying Events

In the event of the divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child, the employee or his beneficiary(ies) must notify the Fund Office within 60 days after the qualifying event occurs. You may send written notice of the event to Michigan Glass and Glazing Industry Welfare Insurance Fund, P.O. Box 966, Troy, MI 48099-0966, or you can report a qualifying event by calling the Fund Office at (248) 641-4957. You or your beneficiary(ies) will be required to send a full copy of your divorce decree, decree of legal separation or death certificate to the Fund Office at P.O. Box 966, Troy, MI 48099-0966, Failure to comply with these rules will result in the permanent loss of COBRA rights.

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If the divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child is not reported to the Fund Office within **60 days** from the **later** of the date you would lose coverage because of the occurrence of one of the events described above **or** the date you were sent your COBRA election notice, continuation of coverage will **not** be permitted. Note that some qualifying events result in an immediate loss of coverage (such as divorce, legal separation and loss of dependent status), and some are determined on a monthly basis (such as termination of employment and loss of hours). Therefore, you should **never delay** in notifying the Fund Office of any qualifying event, or you risk losing your rights under COBRA.

How is COBRA Coverage Provided?

Once the Fund Office receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage must be elected no later than 60 days after the qualified beneficiary receives the COBRA Election Form. If you do not submit the COBRA Election Form by the due date, you will lose your right to elect COBRA continuation coverage.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event (for divorce, legal separation and loss of dependent status), or on the date that Plan coverage would have otherwise been lost (for termination of employment and reduction of hours).

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce, your legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of his Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. *You must make sure that the Fund Office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Fund Office at P.O. Box 966, Troy, MI 48099-0966.*

- **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is

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properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. *In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within 60 days of the second qualifying event's occurrence. You must send this notice to the Fund Office at P.O. Box 966, Troy, MI 48099-0966.*

If you have a newborn child or have a child placed with you for adoption while your COBRA continuation coverage is in effect, you have the right to elect coverage for such child if the Fund receives notice of that birth, adoption or placement for adoption within 30 days of its occurrence. A child born or placed with you for adoption while you are receiving COBRA continuation coverage will have the same COBRA rights as your spouse or dependents who were covered by the Plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, the child's continued coverage depends on the timely and uninterrupted payment of your COBRA payments.

Cost of COBRA Continuation Coverage

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you have to pay the full cost, including a 2 percent administrative surcharge, for your continuation coverage. If the Social Security Administration determines that you were disabled at the time of termination or reduction of hours and you elect to continue coverage beyond the 18 month period, you may be charged an additional 50 percent surcharge beginning on the 19th month of coverage.

You will have a grace period of at least 30 days to pay the monthly COBRA payment, except for the first monthly payment, for which you will have a one-time-only 45 day grace period.

Termination of COBRA Continuation Coverage

The law also provides that you or your dependents' COBRA continuation coverage may be **terminated** by the Fund for any of the following reasons:

- The Fund no longer provides coverage for similarly situated employees;
- Your payment for continuation coverage is not received by the Fund in a timely fashion;
- You or your dependent becomes covered under another group health plan that does not include a preexisting conditions clause that applies to you or to a covered dependent. If you are or become covered under another group health plan, you must notify the Fund Office immediately;
- You are receiving COBRA continuation coverage because of a disability defined under the Social Security Act and Social Security determines that you are no longer disabled. You must notify the Fund Office within 30 days of the date of any final determination by the Social Security Administration that you are no longer disabled; or
- You provide written notice to the Fund Office that you wish to end your COBRA continuation coverage.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office, P.O. Box 966, Troy, MI 48099-0966. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Fund Office Informed of Address Changes and Life Changes

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In order to protect your family's rights, you should keep the Fund Office informed of any changes in your address and the addresses of family members, and in the event of any changes in your family (births, deaths, divorce, legal separation, entitlement to Medicare, etc.) You should also keep a copy, for your records, of any notices you send to the Fund Office.

CREDITABLE COVERAGE FOR PRE-EXISTING CONDITIONS

The Health Insurance Portability and Accountability Act, a federal law, limits the amount of time that group health plans can exclude coverage for a new enrollee's pre-existing health conditions to 12 months (or 18 months for late enrollees). But that waiting period (exclusion period) can be reduced by the number of months the individual was covered previously under another health plan, including COBRA coverage, so long as there has not been a gap of more than 63 days in the individual's coverage.

If your coverage under the Plan ends for any reason, you will receive from the Fund a "Certificate of Group Health Plan Coverage" which you should present to your new group health plan. That new group health plan will then "credit" your months of coverage under this Plan against any exclusion period for pre-existing conditions imposed by the new plan, provided you did not have a gap of more than 63 days in your coverage. You also may request a Certificate within 24 months of loss of coverage.

BENEFITS

BLUE CROSS/BLUE SHIELD OF MICHIGAN (BCBSM) PROVIDED BENEFITS

MEDICAL, HOSPITAL AND SURGICAL BENEFITS

You and your dependents will be enrolled in Blue Cross/Blue Shield of Michigan (BCBSM). Benefits available under this coverage on January 1, 2007 are described in summary below. The Board of Trustees has the right to change, add or terminate benefits at any time. If it does, you will be notified in writing, but if you have questions about your coverage, you should contact Blue Cross/Blue Shield of Michigan and/or the Fund Office.

1. How Your Health Care Plan Works

a. Active Employees and Retirees Under Age 65

If you are an Active Employee or a Retiree under age 65, you have coverage through the Comprehensive Major Medical-PPO (CMM-PPO). You will receive the highest level of benefits and you will incur the least amount of out-of-pocket costs, if any, if you choose CMM-PPO Network Providers. You have coverage for most services provided by Non-Network Providers, but those services will be subject to an additional 20 percent co-payment, in addition to any amount over BCBSM's approved amount. You can limit the out-of-pocket costs for services from Non-Network Providers by choosing Non-Network Providers who are Blues Participating Providers, but you also have coverage for Non-Network Non-Participating Providers. The terms Network Provider, Non-Network Provider, Blues Participating Provider, and Non-Network Non-Participating Provider are defined on pages 22 – 23.

The following information will help you understand how your health care plan works if you are an Active Employee or Retiree under age 65:

- **Referrals** – Services performed by a Non-Network Provider are covered at the in-network level if your CMM-PPO physician coordinates them.

Important: A referral from your CMM-PPO provider does not guarantee payment. To be covered, the service must be a covered benefit and you must have a **written referral** from your CMM-PPO physician.

If you are referred to a Non-Participating Provider, you may be balanced billed and you may have to file your own claims. Therefore, if you are referred to a Non-Network physician who is **also** a Non-

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Participating physician (sometimes referred as a Non-Network Non-Participating provider), be sure to discuss the physician's policy regarding fees, as you may be responsible for paying any amount above the BCBSM approved amount.

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

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

- **CMM-PPO Network Exceptions** – When you receive the following types of covered services from a Non-Network Provider who is a Blues Participating Provider you are not required to pay the 20 percent out-of-network copayment:
 - Ambulance providers
 - Durable medical equipment suppliers
 - Prosthetic and orthotic suppliers
 - Dental expense benefits

Note: The services described above are also covered when rendered by Non-Network Providers who are not Blues Participating Providers (also known as Non-Network Non-Participating Providers). However, you may incur additional out-of-pocket expenses for services rendered by Non-Network Non-Participating Providers.

The following services are covered when received from Non-Network Providers who are Blues Participating Providers, but they are **not** covered when rendered by Non-Network Providers who are not Blues Participating Providers (also known as Non-Network Non-Participating Providers):

- BCBSM-approved home health care agencies
 - BCBSM-approved hospice care programs
 - Freestanding substance abuse treatment programs
 - Freestanding physical therapy facilities
- **Benefit Period** - Payment of your CMM-PPO benefits, including annual dollar maximums, are based on a benefit period or calendar year, beginning January 1 and ending December 31. Your first benefit period may be shorter, depending on your employment date and when you become eligible for coverage.
 - **Payment of Benefits** - Under your health plan, covered services and supplies are called “benefits.” The payment allowed for benefits is called the “approved amount.” BCBSM determines the approved amount and it is the lesser of the billed charge or maximum payment amount allowed for covered services. Applicable deductibles and copayments are deducted from BCBSM's approved amount.

b. Retirees Age 65 and Older

If you are Retiree age 65 or older, you have coverage through Comprehensive Major Medical (CMM). You will receive the highest level of benefits and you will incur the least amount of out-of-pocket costs, if any, if you choose Blues Participating Providers. You have coverage for most services provided by Non-Participating Providers, but you will be responsible for the payment of any amount over BCBSM's approved amount. The terms Blues Participating Provider and Non-Participating Provider are defined on

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page 23.

The following information will help you understand how your health care plan works if you are a Retiree age 65 or older:

- **Medicare Enrollment** - To be eligible for coverage as a Retiree age 65 and older, you must be enrolled in both Medicare Part A **and** Part B, but not Medicare Part D. Benefits under the Plan will be reduced to the extent payment is available under Medicare Parts A and B.

BCBSM's Medicare Supplemental Coverage works with your Medicare coverage to extend your health care benefits. Your group coverage, in combination with Medicare, provides the same benefits that are described in this Summary Plan Description, except where noted. Your Medicare deductible and coinsurance amounts are also covered if the service is included in the benefits described in this Summary Plan Description.

- **Benefit Period** - Payment of your CMM benefits, including annual dollar maximums, are based on a benefit period or calendar year, beginning January 1 and ending December 31. Your first benefit period may be shorter, depending on your employment date and when you become eligible for coverage.
- **Payment of Benefits** - Under your health plan, covered services and supplies are called "benefits." The payment allowed for benefits is called the "approved amount." BCBSM determines the approved amount and it is the lesser of the billed charge or maximum payment amount allowed for covered services. Applicable deductibles and copayments are deducted from BCBSM's approved amount.

2. **Definitions of CMM-PPO Network Provider, Non-Network Provider, Blues Participating Provider, Non-Network Non-Participating Provider**

CMM-PPO Network Provider: A CMM-PPO Network Provider is a hospital, physician, or other provider or supplier of health care services that has signed an agreement with BCBSM to accept BCBSM's approved amount as payment in full for covered services

- To receive benefits at the in-network level, your care must be received from a CMM-PPO Network Provider. However, you do not need to use a CMM-PPO Network Provider where there is no network available.
- BCBSM will pay the approved amount for each medically necessary covered service provided by a CMM-PPO Network Provider.
- Your copayment and/or deductible, if applicable, is subtracted from the approved amount before payment is made. The provider is paid directly for covered services.
- To locate a CMM-PPO Network Provider in Michigan, look in the BCBSM PPO Participating Provider Directory, which is available from the Fund Office. You may also call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227 or visit BCBSM's website at www.bcbsm.com.
- You do not have to choose just one provider for your care and you do not have to notify BCBSM or the Fund Office when you change physicians.

Non-Network Provider: A Non-Network Provider is a hospital, physician, or other provider or supplier of health care services who is not part of the CMM-PPO network.

- Before choosing a Non-Network Provider, you should verify if the service would be covered.

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- If you are covered through the CMM-PPO, you are required to pay an additional 20 percent copayment for services received from a Non-Network Provider in addition to the deductible and copayment required by your Plan. Some services are not covered out-of-network.

Blues Participating Provider: A Blues Participating Provider will bill BCBSM directly for your services and you will not be billed for any difference between the provider's charge and BCBSM's approved amount.

- Blues Participating Providers include physicians and other licensed professional providers, and hospitals and other approved facilities that have signed agreements with BCBSM to accept the BCBSM approved amount for covered services as payment in full, and they will not balance-bill you.
- Blues Participating Providers usually display the BCBSM emblem in their offices.
- Blues Participating Providers bill BCBSM directly. This means you are not required to complete paper work or save and submit receipts.
- Find a Blues Participating Provider by logging onto BCBSM's website at www.bcbsm.com or looking through the provider directory or contacting BCBSM Customer Service at (313) 225-8100 or (800) 637-2227.
- You should schedule your health care appointments directly with a Blues Participating Provider. However, when scheduling your appointment, it is a good idea to confirm that the provider participates with BCBSM. If you would like to verify the provider's participation status, please call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227.

Non-Participating Provider: A Non-Participating Provider has **not** signed an agreement with BCBSM.

- You may have to pay a Non-Participating Provider at the time you receive services. You should then submit the claim to BCBSM.
- If the claim is approved, payment will be sent directly to you and it is your responsibility to pay the provider.
- Non-Participating Providers often charge more than the maximum BCBSM payment level. You may be responsible for paying this difference, plus any deductibles or copayments that apply, including any applicable out-of-network copayment.

3. Coverage Provisions Applicable to All Participants

a. Temporary Benefits for Hospital Services

When a hospital chooses to terminate its contract with BCBSM, your coverage provides temporary benefits for designated services (services that BCBSM determines only a noncontracted area hospital is equipped to provide), emergency care and travel, meals and lodging for up to **six months** from the date the hospital terminates its participating contract with BCBSM.

When temporary benefits are preapproved by BCBSM:

- You will receive payment directly from BCBSM for the covered services. This amount may be significantly less than the amount a nonparticipating hospital charges you.
- You are responsible for paying the nonparticipating hospital and are responsible for any difference between BCBSM's payment and the hospital's charges.
- Your out-of-network copayment and deductible are waived.

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Mandatory Approval: Approval for designated services, travel, meals and lodging **must** be obtained from BCBSM before BCBSM will consider the services for payment. If the required approval is **not obtained**, you must pay for the services you receive. Approval of services is not a guarantee that a claim will be paid. All claims are subject to a review of the reported diagnosis, medical necessity verification, the availability of benefits at the time the claims are processed as well as the requirements, conditions, limitations, exclusions, maximums, deductibles and copayments under your health care plan.

Preapproval must be obtained from BCBSM as follows:

- **Designated Services** - Your physician must obtain preapproval for designated services by calling BCBSM. If preapproval is not obtained, the designated services you receive will not be covered and you will be responsible for the hospital's charges.

If preapproved, **you** will be paid BCBSM's approved amount, less any required deductibles and copayments. BCBSM's approved amount may be less than the hospital's charges and you will be required to pay the difference.

- **Travel, Meals and Lodging** – You must obtain preapproval for any travel, meals and lodging expenses before they are incurred. If you do not obtain preapproval, these services will not be covered and you will be responsible for these costs.

Note: Travel, meals and lodging will be paid only after you submit your receipts to BCBSM.

Inpatient Services: If preapproved, benefits will be paid for the cost of travel, meals and lodging if you live within 75 miles of the nonparticipating hospital and cannot reasonably obtain covered services from a participating hospital and your physician directs you to an out-of-area hospital. You must obtain services from the out-of-area BCBSM participating or network hospital that is closest to the nonparticipating hospital.

The following benefits will be paid:

- Up to \$250 per day for the reasonable and necessary cost of travel, meals and lodging, up to a combined (patient and person(s) eligible to travel with the patient) maximum of \$5,000 per admission
- Meals for the patient and person(s) eligible to accompany the patient up to a combined maximum of \$40 a day
- Lodging for the person(s) eligible to accompany the patient

Note: Coverage begins on the day before the admission and ends on the discharge date.

Outpatient Services: If you require outpatient services from an out-of-area hospital or physician, up to \$125 for travel, meals and lodging will be paid each time you require these services. Physician services must be directly related to an admission to an out-of-area hospital.

BCBSM does **not** pay for:

- Travel via ambulance transport to an out-of-area hospital
- Cost for travel, meals and lodging that exceed the dollar maximums
- Items that BCBSM does not consider directly related to travel, meals and lodging, such as: dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, toys, household products, alcoholic beverages, flowers, greeting cards, stationary, stamps, household utilities (including cellular telephones), maids, babysitters or day care services and entertainment such as cable televisions, books, magazines, movie rentals or

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charges for hospital services that are not covered (telephone, television or private room)

Emergency Care: BCBSM will **pay you** its approved amount, less any required deductibles and copayments, for covered services that are medically necessary. BCBSM's approved amount may be less than the hospital's charges and you will be required to pay the difference.

Ambulance Transportation: If you are admitted to a nonparticipating hospital and your physician determines you are medically stable, you may choose to be transferred to the nearest participating hospital equipped to treat your condition. BCBSM will **pay you** its approved amount, less any deductible or copayment requirements, for your one-way ambulance transport to that hospital.

Note: If you use a nonparticipating ambulance provider, its bill may be more than BCBSM's approved amount. You are required to pay the difference.

Nonparticipating Physicians and Other Professional Providers: You should expect to pay charges to nonparticipating physicians and other professional providers at the time you receive services. After BCBSM approves the claim, BCBSM will send payment directly to you, less your copayments and deductibles. However, because nonparticipating providers often charge more than BCBSM's approved amount, BCBSM's payment to you may be less than the amount charged by your provider. **You are responsible for this difference.**

b. Coverage Outside of Michigan

BlueCard Program: When you need medical care **outside of Michigan**, just call **1-800-810-BLUE (2583)** and you will be directed to the nearest Blue participating provider. BlueCard participating providers will bill their local Blue Plan for covered services you receive. You are responsible only for applicable deductible and copayments, and for services not covered by your plan.

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

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

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

2. When you arrive at the doctor's office or hospital, show your BCBSM ID card. Remind the provider that you are covered under the BlueCard Program and to include the alpha prefix (three characters preceding the contract number on your BCBSM ID card) on all claims.
3. Pay applicable deductibles and copayments required by your plan.

Important: If you receive services from a nonparticipating provider you may need to submit itemized receipts directly to BCBSM. Also BlueCard does not include prescription drugs, dental, vision and hearing services.

Care Out of the Country: Your coverage applies no matter where you are only if the hospital is accredited and the physician is licensed. Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell BCBSM if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. BCBSM will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles or copayments that may apply.

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4. Copayments and Lifetime Limits

Approved Amount - The approved amount is BCBSM's maximum payment level or the provider's billed charge for the covered service, whatever is lower. Copayments, if any, are deducted from the approved amount.

Lifetime Limits - Your covered services are limited to a lifetime dollar maximum of \$5 million per person. This is the most that will be paid for an individual's covered services. Within this \$5 million maximum the following will be paid:

- Up to the annual minimum dollar amount designated by state law for outpatient substance abuse treatment
- Up to \$15,000 annually, \$30,000 lifetime for inpatient substance abuse treatment

Specified organ transplants have a separate \$1 million lifetime maximum that does not contribute to the \$5 million lifetime maximum.

Deductibles – You pay no deductible for covered services.

Copayments for Active Employees and Retirees under age 65 and their dependents (Comprehensive Major Medical – Preferred Provider Organization or CMM-PPO)

The following copayments apply to CMM-PPO benefits:

- **Hospital services for general conditions**
 - **Network Hospitals** – BCBSM pays 100 percent of the approved amount for services for general conditions at hospitals that are CMM-PPO network providers.
 - **Participating Hospitals** - BCBSM pays 80 percent of the approved amount for services for general conditions at hospitals that are participating providers and you are responsible for a 20 percent copayment.
 - **Nonparticipating Hospitals** - BCBSM coverage at Michigan nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency. When hospital services are received at nonparticipating hospitals, the Fund will pay only \$70 per day for inpatient services in acute-care hospitals, \$15 per day in specialty hospitals and \$25 per visit for outpatient hospital services, less the applicable copayment of 20 percent of the approved amount plus any amount above the approved amount. BCBSM will pay its approved amount for emergency services provided by an accredited nonparticipating hospital outside of Michigan if the hospital participates with another Blue Cross/Blue Shield Plan or is located in an area not served by another Blue Cross/Blue Shield Plan.
- **Laboratory services**
 - **Network Laboratories** - BCBSM pays 100 percent of the approved amount for laboratory services provided by CMM-PPO network laboratories.
 - **Participating Laboratories** - BCBSM pays 80 percent of the approved amount for laboratory services provided by participating laboratories and you are responsible for a 20 percent copayment.

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- **Nonparticipating Hospitals** – BCBSM pays 80 percent of the approved amount for laboratory services provided by participating laboratories and you are responsible for a 20 percent copayment, plus any amount above the approved amount.
- **Physician services**
 - **Network Providers** – BCBSM pays 100 percent of the approved amount for services provided by CMM-PPO network providers (for Active Employees and Retirees under age 65), subject to a \$20 copayment for
 - Allergy testing and allergy treatments
 - Office, outpatient and home medical care visits (excludes routine medical care)
 - Well-baby care for infants to age one
 - Immunizations for children up to and including age six
 - **Participating Providers** – BCBSM pays 80 percent of the approved amount for services provided by participating providers and you are responsible for a 20 percent copayment. BCBSM does **not** pay for allergy testing and allergy treatments; office visits, excluding routine medical care; well-baby care for infants up to age one; or immunizations for children up to and including age six provided by participating providers.
 - **Nonparticipating Providers** – BCBSM pays 80 percent of the approved amount and you are responsible for a 20 percent copayment plus any amount above the approved amount. BCBSM does **not** pay for allergy testing and allergy treatments; office visits, excluding routine medical care; well-baby care for infants to age one; or immunizations for children up to and including age six provided by nonparticipating providers.
- **Mental Health Care**
 - Mental health care is not subject to any dollar limits other than the lifetime dollar limit maximum of \$5 million per person that applies to all medical, hospital and surgical benefits.
 - Inpatient mental health care is covered up to 60 days per year with a lifetime maximum of 120 days subject to the above limitations for hospital, laboratory and physician services.
 - Outpatient mental health care is covered when provided through an approved facility or by a physician or fully-licensed psychologist for 50 visits per year and a lifetime maximum of 120 visits, subject to the above limitations for hospital, laboratory and physician services.
- **Substance Abuse Care**
 - Inpatient substance abuse care is covered up to \$15,000 per person per calendar year, up to \$30,000 per person per lifetime, subject to the above limitations for hospital, laboratory and physician services.

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- Outpatient substance abuse care is covered up to the annual minimum dollar amount designated by state law, subject to the above limitations for hospital, laboratory and physician services. *Note:* Since this amount is adjusted annually, you should contact BCBSM for the current benefit amount.

Copayments for Retirees age 65 and older and their dependents (Comprehensive Major Medical or CMM)

The following copayments apply to CMM benefits:

- **Hospital services for general conditions**
 - **Participating Hospitals** – BCBSM pays 100 percent of the approved amount for services for general conditions at hospitals that are participating providers.
 - **Nonparticipating Hospitals** - When hospital services for general conditions are received at nonparticipating Michigan hospitals, the Fund will pay only \$70 per day for inpatient services in acute-care hospitals, \$15 per day in specialty hospitals and \$25 per visit for outpatient hospital services, plus any amount above the approved amount.
- **Laboratory services**
 - **Participating Laboratories** – BCBSM pays 100 percent of the approved amount for laboratory services provided by participating laboratories.
 - **Nonparticipating Hospitals** – BCBSM pays 100 percent of the approved amount for laboratory services provided by participating laboratories and you are responsible for any amount above the approved amount.
- **Physician services**
 - **Participating Providers** – BCBSM pays 100 percent of the approved amount for services provided by participating providers. BCBSM does **not** pay for well-baby care or immunizations.
 - **Nonparticipating Providers** – BCBSM pays 100 percent of the approved amount and you are responsible for any amount above the approved amount for services provided by nonparticipating providers. BCBSM does **not** pay for well-baby care or immunizations.
- **Mental Health Care**
 - Mental health care is not subject to any dollar limits other than the lifetime dollar limit maximum of \$5 million per person that applies to all medical, hospital and surgical benefits.
 - Inpatient mental health care is covered up to 60 days per year with a lifetime maximum of 120 days subject to the above limitations for hospital, laboratory and physician services.
 - Outpatient mental health care is covered when provided through an approved facility or by a physician or fully-licensed psychologist for 50 visits per year and a lifetime maximum of 120 visits, subject to the above limitations for hospital, laboratory and physician services.

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- **Substance Abuse Care**

- Inpatient substance abuse care is covered up to 60 days and \$15,000 per person per calendar year, up to 120 days and \$30,000 per person per lifetime, subject to the above limitations for hospital, laboratory and physician services.
- Outpatient substance abuse care is covered up to the annual minimum dollar amount designated by state law, subject to the above limitations for hospital, laboratory and physician services. *Note:* Since this amount is adjusted annually, you should contact BCBSM for the current benefit amount.

5. Health Care Benefits

This section provides general information about the benefits available to you under CMM-PPO coverage for active employees and retirees under age 65 and their dependents and CMM coverage for retirees age 65 and older and their dependents. Please check each section regarding specific types of coverage for further information regarding your benefits.

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

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

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

- When you don't inform the hospital that you are covered through BCBSM either at the time of admission or within 30 days after you have been discharged.
- When you fail to provide the hospital with information that identifies your coverage.

Service Before Coverage Begins or After Coverage Ends; Unless otherwise stated in this booklet, BCBSM will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at a facility, BCBSM's payment will be based on the facility's contract with BCBSM. BCBSM's payment may cover:

- The services, treatment, care or supplies you receive during the entire admission **or**
- The services, treatment, care or supplies you receive while your coverage is in effect.

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

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

6. Hospital Benefits

A. Hospital Inpatient Benefits

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

General Medical Care Days: You have an unlimited number of inpatient days for the diagnosis and treatment of general medical conditions.

The following types of admissions are also considered general medical care:

- **Maternity and nursery care** – includes delivery room costs and routine nursery care for a newborn during an eligible mother’s hospital stay.

Note: 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- **Cosmetic surgery** – includes correction of birth defects, conditions resulting from accidental injuries or traumatic scars and the correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.
- **Dental surgery** – includes removal of impacted teeth or multiple extractions **only** when there is a concurrent hazardous medical condition, such as a heart condition. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

Mental Health and Substance Abuse Treatment Days: BCBSM will pay up to **60** days per calendar year and a lifetime maximum of **120** days for inpatient mental health and residential substance abuse treatment. Benefits are payable when services are provided in BCBSM-approved hospitals and in approved day- and night-care centers.

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

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

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

Important: Inpatient mental health care and substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. If you are not sure that the criteria will be met, please have your physician call BCBSM's Mental Health Precertification Unit at (800) 762-2382 for guidance.

B. Hospital Services and Supplies

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

- **Anesthesia** – administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service
- **Blood services** – whole blood, blood derivatives, blood plasma and supplies used for administering the services
- **Drugs** – medicines prescribed and given during a hospital admission
- **Durable medical equipment** – items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay
- **Prosthetic and orthotic appliances** – items that are surgically implanted in the body, such as heart valves
- **Special treatment rooms** – operating, delivery and recovery rooms
- **Medical and surgical supplies** – gauze, cotton and solutions used during the hospital admission
- **Diagnostic and radiology services** –
 - **Laboratory and pathology tests** – laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service
 - **CAT and MRI scans** – scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBSM
 - **Diagnostic tests** – EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury
 - **Therapeutic radiology** – radiological treatment by X-ray, isotopes or cobalt for a malignancy
 - **Diagnostic radiology** – ultrasound and X-rays required for the diagnosis of an illness or injury

C. Hospital Outpatient Benefits

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

Pre-Admission Testing: Testing **must** be performed in the outpatient department of a hospital within

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seven days before a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.

Physical, Occupational and Speech Therapy: Physical, occupational and speech therapy benefits include the following treatment:

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

Physical, occupational and speech therapy benefits are payable when provided in:

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

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

Important: Payment for therapy is based on the **diagnosis** and the **location**. Ask your physician or therapist to call BCBSM to verify if the prescribed therapy will be rendered in a payable location before receiving physical 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

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acute injury or illness involving the muscles or joints

Benefits **are not** payable for:

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

Emergency Medical Care: Your coverage provides the following benefits:

Emergency Medical Care in the Emergency Room – Your benefits include the initial exam and treatment of accidental injuries or medical conditions determined by BCBSM to be medical emergencies. A medical emergency is a condition that occurs suddenly and unexpectedly and could result in serious bodily harm or threaten life unless treated immediately.

Note: Routine care for minor medical problems such as headaches, colds, slight fever and back pain is not considered emergency care. Also, follow-up care is not considered emergency care.

Professional Ambulance Services – Ambulance services are covered to transport a patient up to 25 miles unless the destination is the nearest medical facility capable of treating the patient's condition. The service must be medically necessary, prescribed by a physician (when used for transferring a patient) and provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation.

Air ambulance is covered when no other means of transport is available or the patient's condition requires air transport rather than ground ambulance. For air ambulance, the provider must be licensed as an air ambulance service and is not a commercial air carrier.

Benefits **are not** payable for:

- Transportation for the convenience of the patient or the patient's family, or for the preference of the physician
- Ambulance services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation

Outpatient Mental Health Care: Your coverage includes psychological testing, group therapy sessions and family counseling. These services must be through an approved facility or by a physician or fully licensed psychologist.

BCBSM will pay for up to **50** visits per calendar year and a lifetime maximum of **120** visits per person for outpatient mental health care. BCBSM will pay for outpatient psychological testing once per person per calendar year.

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Outpatient Substance Abuse Treatment: Treatment is covered when provided in approved outpatient substance abuse treatment facilities. These benefits are payable up to the annual minimum dollar amount designated by State law.

Reminder: Since the State mandated substance abuse amount is adjusted annually, you should call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227 for the current benefit amount.

Chemotherapy: Treatment is payable in a hospital, in the outpatient department of a hospital, or in a physician's office. Your benefits include the administration and cost of drugs 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.

Your benefits also include three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

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

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

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

7. Alternatives to Hospital Care

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

A. Home Hemophilia Program

Home Hemophilia Program benefits include all medications and medical supplies needed for in-home treatment for hemophilia, including syringes, needles and the antihemophilic factor. You can receive dialysis services in the home, if the owner of the patient's home gives the hospital prior written permission to install the equipment. Your benefits also include training the patient or a family member on how to inject the antihemophilic factor, when the training is provided through an approved facility.

B. Home Health Care

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

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

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

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- Social services and nutritional guidance when requested by the patient's physician
- Physical, speech and occupational therapy are payable when provided for rehabilitation
- Nursing care when supervised by a registered nurse employed by the home health care agency

BCBSM does **not** cover:

- General housekeeping services
- Transportation to or from a hospital or other facility
- Non-prescribed elastic stockings, sheepskin or comfort items such as lotion, mouthwash, body powder, etc.
- Physician services
- Custodial or non-skilled care

C. Home Infusion Therapy

Infusion therapy is the continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

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

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care if the condition can be safely managed in the home
- Medically necessary
- Given by home infusion therapy providers approved by BCBSM

BCBSM will pay for home infusion therapy services whether or not you are confined to the home. Benefits are subject to the deductibles and copayments, *if any*, required by your health plan.

Services include:

- Drugs required for home infusion therapy
- Nursing services needed to administer home infusion therapy and treat home infusion therapy-related wound care
- Durable medical equipment, medical supplies and solution needed for home infusion therapy

Home infusion therapy is subject to the following limitations and exclusions:

- Except for chemotherapeutic drugs, services provided for home infusion therapy under the home health care benefit are not covered separately under your hospital/medical/surgical or prescription drug certificates.
- Services rendered by providers who are not BCBSM-approved home infusion therapy providers will not be covered.
- Drugs required for home infusion therapy services are not limited by any day or visit limits you may have under your certificate. These services will be limited by any lifetime dollar

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maximum required by your health care plan.

D. Skilled Nursing Care

Care in a skilled nursing facility is covered when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. In addition, BCBSM requires written confirmation of the need for skilled care from the patient's physician. Physician benefits for medical care are limited to two visits per week. All services must be provided at a participating skilled nursing facility.

A skilled nursing facility is 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.

Benefits are **not** payable for:

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

E. Hospice Care

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

The patient or a representative of the patient should apply for hospice care benefits after discussion with and referral by the attending physician. The request must be in writing to the hospice agency **and all hospice services must be arranged through an approved hospice provider.**

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

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

- **Levels of Care** – The hospice program provides four levels of care:
 - **Routine home care** that consists of services provided to patients who are living at home and are not receiving continuous home care (see next item). Benefits include counseling, home health care and physical therapy. Such care must not exceed eight hours per day.
 - **Continuous home care** that consists of nursing care services provided to patients during crisis periods to enable them to stay at home. Such care is covered up to 24 hours per day during periods of crisis.
 - **Inpatient respite care** that consists of short-term inpatient services to allow the home care provider short periods of relief. Such care must be provided in an approved facility on a non-

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routine or occasional basis and in increments of five days or less in any 30-day period.

- **General inpatient care** that consists of services for pain control and acute and/or chronic symptom management that cannot be provided in other less intensive settings.
- **Hospice Services** – The following benefits are payable under the hospice program up to the dollar maximum amount that is reviewed and adjusted annually. Please call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227 for the current maximum amount.
 - **Nursing care** when provided by or under the supervision of a registered nurse
 - **Medical social services** by a qualified social worker, provided under the supervision of a physician
 - **Counseling services** for the patient and caregivers, when care is provided in the home and for family bereavement after the patient's death
 - **Medical appliances and supplies** to provide comfort to the patient and when approved by BCBSM
 - **Durable medical equipment** when furnished by the hospice program for the patient's home
 - **Physical, speech and occupational therapy** when provided to control symptoms and maintain the patient's daily activities and basic functional skills

Important: Hospice benefits are covered at 100 percent of the approved amount. There is a separate dollar maximum for services provided by a physician who is not part of the hospice team. Please call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227 for information about the current dollar maximum.

8. **BlueHealthConnection® Program**

BlueHealth Connection is an integrated health care management program that provides you with the information, assistance and decision-making tools you need to take charge of your personal health care needs. It gives you access to:

- **Nurse health coaches** 24 hours per day, seven days a week
- **Guided self-management** tools such as web-based information, self-help handbooks and videos
- **Outreach programs** by telephone or mail to assist you in understanding the use of services available through BlueHealthConnection
- **Integrated case and disease management** for patients with chronic illnesses like diabetes or heart disease or acute illness

Note: Integrated case and disease management (ICDM) is a voluntary program designed to help manage the health care of individuals with acute or chronic medical conditions, regardless of setting. The candidates for this program must meet the eligibility criteria listed below. Noncontractual services will be paid only when such services are specifically described in a signed treatment plan.

Eligibility for Integrated Case and Disease Management (ICDM) - BCBSM decides who is eligible for ICDM based on the following factors:

- Candidate's diagnosis
- Admission status
- Clinical status

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

Candidates for ICDM may be identified based on BCBSM claims data. In addition, BCBSM will consider referrals of candidates from such sources as:

- Attending physicians
- Hospitals
- Candidate or candidate's family
- The Fund

Personal Treatment Plan - When the individual is accepted as a candidate for ICDM, a personal treatment plan will be developed.

- The personal treatment plan describes the goals, expected outcomes, type and limited duration of services to be provided to the individual under ICDM. It may include medically necessary services that BCBSM determines should be provided because of the individual's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.)
- The individual's physician must order all services described in the treatment plan. **Only the services, equipment and supplies specifically described in the signed treatment plan will be paid. The signed treatment plan is a binding contract between the individual and BCBSM.**

Termination of ICDM - BCBSM may terminate the treatment plan and the individual's participation in ICDM if:

- The individual is no longer eligible to receive benefits under his or her BCBSM certificate.
- The individual voluntarily withdraws from the program.
- The individual meets the treatment plan goals. (Termination in these cases occurs when the case manager determines that the goals have been met. As a result, termination may occur well before any expiration period described in the treatment plan is reached.)
- The individual fails to meet the treatment plan goals within the time period specified in the treatment plan.
- The time period described in the individual's treatment plan expires.
- The individual (or his or her representative), treating physician or case manager determines that the individual's participation in case management will no longer result in measurable improvement in the individual's clinical status.

Limitations and Exclusions of the ICDM program - The following limitations and exclusions apply to the Integrated Case and Disease Management program:

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- Benefits provided under the ICDM program are applied to the lifetime maximum of your certificate, except where specifically waived by BCBSM.
- Services described in the treatment plan will be provided only as long as the plan is in effect.
- Coverage for non-contractual services under ICDM will only be provided for the specific conditions identified in the treatment plan. Treatment for other conditions remains subject to the terms of your underlying certificate(s).
- BCBSM does not pay for any services provided by a relative of the patient.

9. Human Organ Transplants

The following types of human organ transplants are covered when received at a participating hospital or, where noted, in a BCBSM-approved transplant facility, and designated transplant facility. **Call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227 with questions you have about cornea, kidney or skin transplants. Call the BCBSM Human Organ Transplant Program at (800) 242-3504 for any questions you have about bone marrow or specified human organ transplant surgery.**

A. Organ and Tissue Transplants

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

- Cornea
- Kidney
- Skin

Covered services for a donor will be paid if the donor does not have transplant benefits under any health care plan.

Note: To determine donor benefits please call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227.

B. Hematopoietic Transplants

Your transplant benefits include transplants of the bone marrow, peripheral blood stem cells or umbilical cord blood. Benefits are payable for up to a maximum of two single transplants per patient per condition. The lifetime dollar maximum, deductibles and copayments, *if any*, required under your health care plan apply to these transplant services.

Note: There is **no** travel benefit associated with this coverage.

- **Allogeneic (Allogenic) Transplants**

Benefits for allogeneic transplants are payable only when the bone marrow, peripheral blood stem cells or umbilical cord blood of another person is transplanted into the patient. This includes syngeneic transplants, a procedure using the bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient. BCBSM covers the following services:

- Blood tests on immediate family members (mother, father, sister or brother) for evaluation as donors (if tests are not covered by the potential donor's health coverage)
- 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.)

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- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cells pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood:
 - If the donor is an immediate relative (mother, father, sister or brother) and has four of the six important HLA genetic markers as the patient.
 - **Donors outside of the immediate family must match five of the six important HLA genetic markers with the patient.** This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.

Note: Harvesting and storage will be covered if it is not covered by the donor's health coverage. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Aplastic anemia
- Beta Thalassemia
- Chronic lymphocytic leukemia
- Chronic myeloid leukemia
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Glanzmann thrombasthenia
- Hodgkin's disease (high risk, refractory or relapsed patients)
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- Mantle cell lymphoma
- Megakaryocytic thrombocytopenia
- Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact

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- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
 - Multiple myeloma
 - Myelodysplastic syndromes
 - Myelofibrosis
 - Neuroblastoma (stage III or IV)
 - Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
 - Osteopetrosis
 - Paroxysmal nocturnal hemoglobinuria
 - Primary amyloidosis (AL)
 - Severe combined immune deficiency disease
 - Sickle Cell Anemia (ss or sc)
 - Wiskott-Aldrich syndrome
 - X-linked lymphoproliferative syndrome
- **Autologous Transplants**

Benefits also include transplants of the patient's own bone marrow (autologous) and/or transplanting the patient's own peripheral blood stem cells. BCBSM covers cover the following services:

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cells pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

Note: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes. Benefits are payable for up to a maximum of two tandem transplants, or one single and one tandem transplant per patient.

Autologous transplants are covered to treat the following conditions:

- 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 (high risk, refractory or relapsed patients)

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- Mantle cell lymphoma
- Medulloblastoma
- Multiple myeloma
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Primary amyloidosis
- Primitive neuroectodermal tumors
- Rhabdomyosarcoma
- Wilms' tumor

Benefits are **not** payable for:

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

10. Specified Oncology Clinical Trials

Benefits are payable for bone marrow and peripheral blood stem cell transplants, their related services, and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

In order for services to be payable as eligible benefits:

- The inpatient admission to a hospital and the length of stay at the hospital **must** be medically necessary (in those cases requiring inpatient hospital treatment) and **preapproved**. A request for an admission and length of stay must be preapproved by BCBSM before the admission occurs.

Note: A preapproval is good only for one year after it is issued. However, preapproval services, admissions or lengths of stay will not be paid if you no longer have this coverage at the time services occur.

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If your condition or proposed treatment plan changes after preapproval is granted, your provider must submit a new request for preapproval. Failure to do so will result in the transplant, related services, admission and length of stay not being covered.

- The proposed services **must** be medically necessary and rendered in a designated cancer center or in an affiliate of a designated center. The designated cancer center must submit its written request for preapproval to BCBSM Human Organ Transplant Program.

A designated cancer center is a site approved by the National Cancer Institute (NCI) as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request. An affiliate cancer center is a health care provider that has contracted with an NCI-approved cancer center to provide treatment.

- The patient **must** be an eligible BCBSM participant with hospital/medical/surgical coverage.

Covered Services: Covered services are payable when directly related to a transplant covered under this benefit. When **preapproved** by BCBSM, the following services are covered:

- Autologous transplants
 - Infusion of colony stimulating growth factors
 - Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
 - Purging or positive stem cell selection of bone marrow or blood stem cells
 - High dose chemotherapy and/or total body irradiation
 - Infusion of bone marrow and/or peripheral blood stem cells
 - Hospitalization
- Allogeneic transplants
 - Blood tests to evaluate donors (if not covered by the potential donor's insurance)
 - Search of the National Bone Marrow Donor Program Registry for a donor (A search will begin only when the need for a donor is established.)
 - Infusion of colony stimulating growth factors
 - Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow, peripheral blood stem cells and/or umbilical cord blood (BCBSM will cover harvesting and storage even if the donor's insurance does not cover it.)
 - High dose chemotherapy and/or total body irradiation
 - Infusion of bone marrow, peripheral blood stem cells and/or umbilical cord blood
 - T-cell depleted infusion
 - Donor lymphocyte infusion
 - Hospitalization

Travel, Meals and Lodging: BCBSM will pay up to a total of \$5,000 for travel, meals and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred

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during the period that begins on the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect. BCBSM will pay the expenses of an adult patient and one companion (or two companions if the patient is under age 18).

Within the above \$5,000 limit, the following amounts apply to the **combined** expenses of the patient and eligible companion(s):

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

Benefits are **not** payable for:

- A hospital admission or a length of stay at a hospital that has not been **preapproved**
- Services that have not been **preapproved**
- Services that are not medically necessary
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to a donor when the donor's health care coverage will pay for such services
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
- More than two single transplants per person for the same condition
- Items, such as investigational drugs that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
- Nonhealth care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Items that are not considered directly related to travel, meals, and lodging expenses. They include, **but are not limited to**, dry cleaning, clothing, laundry services, kennel fees, entertainment (cable televisions, movie rentals, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers, cards, stationery, stamps, household products, household utilities, including cell phone charges, maid, baby-sitter or day care services.
- Experimental and investigational services not included in this benefit
- Any other services, admissions or lengths of stay related to any of the above exclusions

11. Specified Human Organ Transplants

Your benefits include coverage for specified human organ transplants performed during the transplant benefit period, as described below, when the transplant is preauthorized by BCBSM and received at a BCBSM-designated transplant facility. A BCBSM-designated transplant facility is one that BCBSM determines to be qualified to perform a specific organ transplant.

Benefits apply only to transplants of the:

- Liver
- Partial liver (a portion of the liver from a cadaver or living donor)

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- Heart
- Lung(s)
- Lobar lung (a portion of a lung from a cadaver or living donor to a recipient)
- Heart-lung(s)
- Pancreas
- Simultaneous pancreas-kidney
- Small intestine (small bowel, a procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver)
- Combined small intestine-liver

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

Benefits are limited to a \$1 million **lifetime** maximum per person for each covered human organ transplant type.

Note: During the benefit period, the deductible and copayments do not apply to the specified organ transplants and related procedures described in this section.

When directly related to the transplant, the following medically necessary services will be paid:

- Facility and professional services.
- Anti-rejection drugs and other transplant-related prescription drugs during and after the benefit period. Payment will be based on the BCBSM approved amount. BCBSM's payment for the drugs is limited only by the \$1 million lifetime maximum.
- 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. Any medically necessary service needed to treat a condition as a direct result of the organ transplant surgery will be paid if it is a benefit under any of BCBSM's certificates.
- Up to \$10,000 for travel, meals and lodging. This includes:
 - Cost of transportation to and from the designated transplant facility for the patient and one companion eligible to accompany the patient (or two companions if the patient is under age 18 or if the transplant involves a living related donor).
 - Reasonable and necessary costs of lodging for the companion(s) eligible to accompany the patient.
 - Reasonable and necessary costs of meals up to a combined maximum of \$40 per day for the patient and companion(s) eligible to accompany the patient.
- The cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ. Also 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 type will not be more than the \$1 million lifetime maximum.

Benefits are **not** payable for:

- Services that are not BCBSM benefits
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant

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- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval
- Transplant surgery and related services that are not performed in a BCBSM designated transplant facility. You must pay for the transplant surgery and related services you receive in a nondesignated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered directly related to travel, meals and lodging expenses. They include, but are not limited to, dry cleaning, clothing, laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers, cards, stationery, stamps, household products, household utilities including cell phone charges, maid, babysitter, and day care services.
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage
- Experimental transplant procedures

12. Physician Benefits

A. Medical Necessity

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

- The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition, or illness. It is not mainly for your convenience or the convenience of physicians.
- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.
- In the absence of established criteria, medical necessity will be determined by physician or professional review according to generally accepted standards and practices.
- The BCBSM determination of medical necessity for **payment** purposes is based on standards of practice established by physicians.

B. Preventative Care Services

Your coverage includes the following preventative services:

Routine Physical/Gynecological Exam - covers one annual physical **or** gynecological examination and the following services every 12 months:

- Chemical profile
- Complete blood count
- Fecal occult blood screening

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- Urinalysis
- Pap Smear - covers laboratory services for one routine pap smear every 12 months (from the date of any previous pap smear). More frequent pap smears are covered 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

Mammography screening – covers one mammogram (breast X-ray) for a woman from the age of 35 to 40. At 40 and older, one mammogram per calendar year is covered. More frequent mammograms are covered if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.

Well-baby care (CMM-PPO coverage only) – covers routine visits for infants up to one year of age. (Benefits are subject to a \$20 copayment.)

Immunizations for children (CMM-PPO coverage only) – covers immunizations for children up to and including the age of six. Covered immunizations are determined in accordance with the recommendations of the Advisory Committee on Immunizations Practices (ACIP) and the American Academy of Pediatrics (AAP). (Benefits are subject to a \$20 copayment.)

C. Office Visits

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

D. Allergy Services

Your coverage includes allergy testing, survey testing, and therapeutic injections when performed by or under the supervision of a physician. (CMM-PPO benefits are subject to a \$20 copayment. There is no copayment for CMM benefits.) Benefits are not payable for fungal or bacterial skin tests, such as those given for tuberculosis or diphtheria, self-administered or over-the-counter medications, psychological testing, evaluation or therapy for allergies, environmental studies, evaluation or control.

E. Chiropractic Services

Your coverage includes the following chiropractic services:

- **New patient office visits** - covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.
- **Office visits** – covers one every calendar year for established patients
- **Chiropractic traction** – number of payable visits is determined by your physical therapy benefit
- **Chiropractic manipulation** – limited to one per day, subject to the following guidelines:

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- A condition for which the patient is being treated for the first time is considered acute and includes up to 20 visits during the first 90 consecutive days
- After the first 90 days, the condition is considered chronic and coverage is limited to two visits per month

F. Maternity Care

You have coverage for obstetrical services including delivery and pre- and post-natal care visits. The initial inpatient examination of the newborn is a benefit when performed by a physician other than the anesthesiologist or the delivering provider.

Note: Maternity care benefits also are payable when provided by a Certified Nurse Midwife. Delivery must be in a hospital or BCBSM-approved birthing center.

Newborns' and Mothers' Health Protection Act Notice: Group health plans and health insurance carriers offering group health coverage 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require a provider to obtain authorization from the plan or insurance carrier for prescribing a length of stay not in excess of the above period. 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 for a caesarian section).

G. Surgical Services

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

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

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

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

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wisdom teeth) or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition exists, such as a heart condition. 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.
- Your surgical services also include:
 - **Technical surgical assistance (TSA)** – TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient and in an approved ambulatory surgery facility.
 - **Anesthesia** – Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to a certified registered nurse anesthetist. BCBSM does **not** pay for local anesthesia.
 - **Temporomandibular Joint Syndrome (TMJ) or Jaw-Joint Disorder** - Benefits for TMJ or jaw-joint disorder are limited to surgery directly to the jaw joint, X-rays (including MRIs) and arthrocentesis (injection procedures). However, some symptom-management services are covered such as office visits, reversible appliance therapy, physical medicine (diathermy, hot and cold applications) and medications. Other than the exceptions noted, benefits are not payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint, skull and the muscles/nerves/tissue related to the jaw joint. These exclusions include (but are not limited to): crowns, inlays, caps restorations, grindings, orthodontics, dentures, partial dentures or bridges. If you are not sure that your prescribed treatment will be covered, ask your physician to contact BCBSM for approval before treatment begins.

Note: Irreversible treatment of the mouth, teeth, or jaw is intended to bring about permanent change to a person's bite or position of the jaws. It includes but is not limited to dentures, bridges, crowns, caps, inlays, restorations, grinding and orthodontics. **Reversible** treatment of the mouth and jaw is **not** intended to result in permanent alteration of the bite or position of the jaws; it is directed at managing the patient's symptoms.

H. Emergency Care

Your coverage provides payment of the approved amount for the initial exam and treatment of accidental injuries or conditions determined by BCBSM to be medical emergencies as described on page _____. Routine care for minor medical problems such as headaches, colds, slight fever or back pain is not considered emergency care.

I. Inpatient Medical Care

Medical supervision by the attending physician is payable while you are in the hospital or in a skilled nursing facility for general medical conditions that are not related to surgery or maternity care. Inpatient medical care in a skilled nursing facility is limited to two visits per week.

J. Inpatient and Outpatient Consultations

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

K. Diagnostic and Radiation Services

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

- **Diagnostic radiology** – covers X-rays, ultrasound, radioactive isotopes, and Magnetic Resonance Imaging (MRI) and CAT scans of the head and body when performed for an eligible diagnosis
- **Laboratory and pathology tests**
- **Diagnostic tests** – covers EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies
- **Radiation therapy** – covers radiological treatment by X-ray, isotopes or cobalt for a malignancy

13. Other Covered Services

A. Outpatient Diabetes Management Program

BCBSM pays its approved amount for selected services to treat and control diabetes when determined to be medically necessary and prescribed by an MD or DO. The services are:

- Blood glucose monitors
- Blood glucose monitors for the legally blind
- Insulin pumps
- Test strips for glucose monitors
- Visual reading and urine test strips
- Lancets
- Spring-powered lancet devices
- Syringes
- Insulin
- Medical supplies required for the use of an insulin pump
- Non-experimental drugs to control blood sugar
- Medication prescribed by a doctor of podiatric medicine, MD or DO that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes
- Diabetes self-management training conducted in a group setting, whenever practicable, if:
 - Self-management training is considered medically necessary upon diagnosis by an MD or DO who is managing your diabetic condition when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
 - Your MD or DO diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment

The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health.

Note: Syringes, insulin and prescription drug benefits are provided if you do not have coverage under a

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prescription drug certificate.

B. Blood Services

Whole blood for transfusions is covered.

C. Oxygen and Other Therapeutic Gases

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

D. 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.

E. Dental Services

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

F. Durable Medical Equipment (DME)

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

BCBSM does **not** cover:

- Exercise and hygienic equipment
- Comfort and convenience items
- Self-help devices, such as elevators
- Deluxe equipment, such as motorized wheelchairs, unless medically necessary and required so patients can operate the equipment themselves
- Experimental or investigational equipment

G. Medical Supplies

BCBSM pays for medical supplies and dressings for use in the home when prescribed by a physician for the treatment of a specific medical condition.

H. Prosthetic and Orthotic Appliances

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

A device that replaces a limb or part of a limb **must be furnished by a provider who is fully accredited**

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by the American Board of Certification in Orthotics and Prosthetics, Inc. (ABC). Please call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227 for information about a provider's status.

BCBSM does **not** cover:

- Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, corsets, shoe inserts and supportive appliances for the feet, and corrective shoes, unless the shoe is attached to a medically necessary brace
- Devices for the diagnosis or treatment of reversible or irreversible jaw joint disorders
- Hearing aids
- Spare prosthetic devices
- Routine maintenance of the prosthetic device
- Prosthetic devices that are experimental
- Hair prostheses such as wigs, hair pieces, hair implants, etc.

I. 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.

Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The attending physician must complete a Certification Statement each month the patient is required to have private duty nursing care.

14. BCBSM Exclusions

Note: This list is not all inclusive. See the Exclusions and General Limitations at the end of this booklet.

- Care and services available at no cost 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 exists
- Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than as specified in this booklet
- Medical services or supplies provided or furnished while coverage is not in effect (that is, **before** the effective date of coverage or **after** the coverage termination date)
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), basal metabolism tests or

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electrocardiography

- 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
- Premarital or pre-employment exams
- 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 certificate offered by Blue Cross/Blue Shield of Michigan or another Blue Cross/Blue Shield plan
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which a person is eligible (These services are not payable even if you have not signed up to receive the benefits provided by such programs.)
- Cosmetic surgery and related services solely for improving appearance, except as specified in this booklet
- Treatment of a condition caused by military action or war, declared or undeclared
- Services, care, devices or supplies considered experimental or investigational
- Services for which a charge is not customarily made; services for which the patient is not obligated to pay or services without cost
- Hearing exams and preparation, fitting or procurement of hearing aids
- Vision exams and eyeglasses or other corrective vision appliances
- Services that are not included in your plan coverage documents
- Transportation and travel except as specified in this booklet
- Screening services, unless otherwise stated, excluding mammograms
- Deductibles or copayments paid by the individual under any other certificate
- Physical therapy services performed by a chiropractor
- Services, care, supplies or devices not prescribed by a physician
- Services provided during non-emergency medical transport
- CMM coverage (for retirees age 65 and older and their dependents) **excludes** coverage for well-baby care visits and immunizations

DENTAL EXPENSE BENEFITS

1. Out-of-Pocket Costs and Benefit Maximums

The following information will help you understand how your dental benefits are paid.

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Benefit Period - The benefit period for dental coverage is the 12 month period beginning on the effective date of coverage or renewal by the group.

Your Copayments - Dental procedures are divided into types or classes of service. The class of service determines the amount BCBSM pays. You are required to pay a copayment, which is a portion of the approved amount, for most classes of services. Your copayments, shown in the chart below, are based on the BCBSM approved amount.

Class of Dental Service	Your Coverage Pays	Your Copayment Is
Class I	100% of the approved amount	0% of the approved amount
Class II	50% of the approved amount	50% of the approved amount
Class III	50% of the approved amount	50% of the approved amount
Class IV	50% of the approved amount	50% of the approved amount

Dollar Maximums – BCBSM will pay dental benefits up to the following dollar maximums, per person:

- \$1,500 **annually** for Class I, II and III services combined

You are responsible for any charges that exceed the annual maximum.

- \$1,500 **lifetime** for Class IV (orthodontic) services

Orthodontic services are payable only for dependent children until the end of the month in which they reach age 19 up to a lifetime maximum of \$1,500 per person. BCBSM pays 50 percent of approved amounts for orthodontic services. You are responsible for any charges that exceed the lifetime maximum, up to the BCBSM approved amount for the service.

2. **Choosing Your Dentist**

The Blue **Traditional Plus** dental plan gives you three 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.

A. **DenteMax Network Dentists**

When you choose a DenteMax network dentist, you usually have the lowest out-of-pocket costs because your copayment is based on a discounted amount, which is usually lower than BCBSM's approved amount. When choosing this option, you do not have to use just one dentist or notify BCBSM when you change dentists.

DenteMax dentists file your claims and receive payment directly from BCBSM. You are responsible only for your copayments and for any non-covered services. You can locate a network dentist near you by:

- Logging onto the DenteMax website at www.dentemax.com or the BCBSM website at www.bcbsm.com
- Looking through the DenteMax dental network directory (You should still confirm with your dentist that he or she is in the network)
- Calling BCBSM Customer Service at (313) 225-8100 or (800) 637-2227.

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B. Blues Participating Dentists

Blues Participating dentists participate with BCBSM on a “*per claim*” basis by checking “payment to dentist” on the Dental Claim Form, so it's important to ask if your dentist participates before every procedure. If your dentist chooses to participate, it means he or she will accept BCBSM's approved amount, less your copayments, as payment in full for dental benefits.

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

C. Nonparticipating Dentists

If your dentist is **not** in the DenteMax dental network and chooses **not** to participate with BCBSM, he or she can bill you for any differences between BCBSM approved amount and his or her charges. This would be in addition to your copayments and charges for any non-covered services.

Although nonparticipating dentists can file claims for you, it is submitted as “pay subscriber,” which means BCBSM sends you the payment. You are responsible for paying the dentist.

3. How Your Dental Plan Works

The following information will help you understand how your dental benefits are paid.

Dental Necessity - A dental service must be dentally necessary and appropriate according to generally accepted standards and patterns of dental practice to be covered. Dental necessity is determined by dentists acting for BCBSM, based on criteria and guidelines developed by dentists for BCBSM who are acting for their respective peer provider type or specialty.

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the patient or dentist.
- Covered services are subject to certain restrictions based on:
 - Policies consistent with generally accepted standards of dental practice
 - Those specific contracts that only pay for the least expensive acceptable treatment
- In the case of diagnostic testing, the results are essential to and are used in diagnosis or management of the patient's condition.

Note: In the absence of established criteria, dental necessity will be determined according to accepted standards and practices by dentists acting for BCBSM.

Predetermination of Benefits - Predetermination gives your dentist an opportunity to submit proposed treatment plans for BCBSM's review before beginning services. This voluntary process lets you know whether certain procedures will be covered and how much BCBSM will pay before the services are performed. Dentists usually use this procedure for complex or expensive procedures or to determine if an alternative course of treatment is available.

Here's how predetermination works:

- Your dentist submits the proposed treatment plan and cost to BCBSM **before** your treatment begins.
- BCBSM reviews the treatment plan and determine the amount of benefits available. Consideration is given to alternative procedures and courses of treatment.

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- BCBSM notifies your dentist of the estimated benefits payable for the planned treatment or another course of treatment.

Your coverage is subject to the annual benefit maximum available and frequency (time) limitations at the time services are **actually** received.

Note: Predetermination of benefits does not guarantee that the services will be paid. Payment will be based on the availability of benefits at the time the services are provided and on other requirements, conditions, limitations and exclusions of your dental coverage. If BCBSM later determines that a treatment did not meet its dental necessity criteria, BCBSM has the right to recover the amount paid for services up to two years from the date BCBSM paid for them. In cases involving fraud, there is no time limit for recovering BCBSM's payment.

Alternative Treatment Plan - Sometimes your dental condition can be treated in more than one way. If more than one procedure meets accepted standards of dental care for your condition, such as a partial instead of a bridge, your benefits will be based on the least costly alternative. Of course, you do not need to choose the treatment BCBSM approves, but the most BCBSM will pay is the amount allowed for that treatment. That amount can be applied to the cost of the treatment you select. You will be responsible for charges that exceed BCBSM's allowed amount. BCBSM encourages you to discuss your treatment plan with your dentist so you fully understand what your total out-of-pocket costs will be.

4. What's Covered

You have coverage for the following classes of services. Some services may be subject to medical and/or dental necessity review.

Class I – Preventive Services Benefits:

- Oral exams, twice per benefit year
- A set (up to 4) of bitewing X-rays, twice per benefit year
- Full-mouth and panoramic X-rays, once every 60 months
- Teeth cleaning, twice per benefit year
- Fluoride treatment, twice per benefit year
- Space maintainers for missing posterior (back) primary teeth for individuals under age 19, one per quadrant per lifetime (Space maintainers are not payable for front baby teeth.)
- Diagnostic tests and laboratory exams
 - Pulp tests, once per visit (If an exam, evaluation or restorative, endodontic, periodontal or prosthetic service is performed at the same visit, the pulp test is considered part of the service.)
 - Study models, every 60 months per provider

Class II – Restorative Services Benefits:

- Fillings (amalgam, resin, composite or similar materials)
 - **Replacement** fillings for permanent teeth once every 24 months, and for primary teeth once every 12 months
 - Resin or composite fillings on anterior teeth and posterior surfaces

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- Substructures for permanent teeth only, one per tooth in any 60-month period
- Onlays, crowns and veneers when a tooth cannot be restored with materials such as amalgam, composite or resins, for permanent teeth only for individuals age 12 or older (Replacement of these cast restorations are payable once every 60 months.)
- Recementing crowns, veneers, onlays, and bridges, three times per benefit year after six months from original restoration
- Extractions and surgical removal of teeth and roots
- Surgical exposure of unerupted teeth
- Alveoloplasty (smoothing of bone) or stomatoplasty (recontouring soft tissue) needed to prepare for a denture
- Drainage of cellulitis or facial space abscess of the mouth or surrounding tissues
- Frenulectomy
- Removal of exostosis
- Excision of hyperplastic tissue per arch
- Root canal treatment for a permanent tooth with one or more canals, once every 12 months
- Vital pulpotomy for primary teeth
- Apical surgery for permanent teeth
- Hemisection for permanent teeth
- Scaling and root planing, including curettage and polishing of teeth, once every 24 months per quadrant
- Periodontic surgical services, once every 36 months per quadrant
- Occlusal adjustments, up to five times in a 60-month period (Full-mouth occlusal adjustments are not covered.)
- Occlusal biteguards, once every 12 months
- General anesthesia or IV sedation in connection with oral or dental surgery
- Office visits for observation, when no other treatment is rendered at the same visit
- House and hospital calls
- Professional consultations for a second opinion by another dentist not rendering any treatment
- Antibiotic injections
- Palliative (emergency) treatment, when no other treatment is provided on the same date, except limited X-rays
- Adjustment of a denture six months or more after installation
- Relining or rebasing of a partial or complete denture, once every 36 months per arch
- Tissue conditioning, once every 36 months per arch
- Repair and adjustments of a partial or complete denture

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Class III – Construction of Dentures and Bridges Benefits:

- Removable dentures (complete and partial)
- Stayplates to replace recently extracted front teeth
- Bridges (fixed partial dentures), including abutment crowns and pontics (artificial teeth that replace missing teeth) for individuals age 16 or older

Note: BCBSM will not pay for a replacement denture or bridge until five years after the original was installed.

Class IV – Orthodontic Services Benefits:

- Minor treatment for tooth guidance appliances
- Minor treatment to control harmful habits
- Interceptive and comprehensive orthodontic treatment
- Post-treatment stabilization
- Cephalometric film (skull) and diagnostic photos

Note: BCBSM will not pay for orthodontic services for individuals over age 19.

BCBSM does **not** cover:

- Orthodontic services provided before the effective date of coverage. (If a treatment program began before the effective date, BCBSM will only pay for the services actually performed on or after the effective date of coverage.)
- Functional or myofunctional therapy when not in connection with appliance therapy
- Functional or myofunctional therapy by a speech therapist

5. What's Not Covered

Your dental care coverage does **not** cover:

- Charges for missed appointments or for completing claim forms and other charts or reports
- Charges for instruction in oral hygiene, diet, plaque control programs and dental sealants
- Services and supplies not necessary for the diagnosis or treatment of a dental condition or injury or not recommended and approved by the attending dentist
- Services that are experimental, investigative, or do not meet standards of the profession
- Services solely for cosmetic purposes or personalized services or supplies, such as bonding or veneers when there is no decay or fracture, or bleaching of teeth
- Replacement of fillings for cosmetic reasons or restorations for cosmetic reasons
- Surgery, anesthesia and diagnostic services that are normally covered by your medical plan
- Care received at a medical or dental clinic provided or maintained by an employer
- Services covered by workers compensation laws
- Services covered by government-sponsored health care programs, such as Medicare

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- Services received for dental diseases, or services for the treatment of illnesses or injuries resulting from declared or undeclared acts of war
- Services, treatment, care or supplies provided or started **before** the effective date of coverage
- Services, treatment, care or supplies provided **after** coverage ends except for a crown, bridge or denture if:
 - It is ordered or final impressions have been completed before coverage ends
 - The procedure is completed or the appliance is installed within 60 days of the date coverage ended
- The most costly treatment when two or more methods are available to treat the condition (BCBSM pays the approved amount, less copayment, for the less costly treatment.)
- Treatment by other than a dentist or oral surgeon, except for treatment provided by a licensed dental hygienist under the supervision of a licensed dentist and within the scope of the hygienist's license
- Services by a student at a dental or medical school
- Services or supplies for which no charge is made, or for which you are not legally obligated to pay
- Facility fees or any additional fees that a dentist, physician or hospital charges for treating a patient at a hospital
- Desensitizing medications
- Oral medications, topically applied antibiotics, antibiotic impregnated fibers, non-antibiotic injections, prescriptions and other drugs
- Premedications, local anesthetic or analgesic billed as a separate service
- Charges for infection control and barrier techniques
- Supplies and equipment for use at home, such as mouth trays and electric toothbrushes
- Restorations to adjust or restore missing tooth structure due to abrasion, attrition, or erosion; to stabilize the teeth or to correct the vertical dimension; to strengthen a tooth, prevent a future problem or close a space
- Separate fees for services related to restorations, such as etchings, bases, liners, temporary crowns or fillings, local anesthesia, preparative and other supplies considered part of the total fee for the services or procedure
- Diagnostic mounted case analysis for reconstruction
- Full-mouth reconstruction to change the occlusion or vertical dimension
- An obturator to correct a defect, such as a cleft palate
- Artificial and endodontic implants and related services, including repair and maintenance of implants and surrounding tissues
- Drugs and medications not dispensed by the dentist and those available without a prescription or used in connection with noncovered services
- Antibiotic prophylactic or behavior management pre-medication
- Periodontal surgical barriers and guided tissue regeneration
- Periodontal splinting
- Bone grafts when performed with restorative or endodontic services, extractions or dental implants
- Temporary crowns, bridges or complete dentures
- Duplicate or spare complete or partial dentures
- Replacement of lost, missing or stolen restorations, appliances or prosthetics

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- Personalization or characterization of dentures
- Precision attachments and/or cores, copings or retainer bars for overdentures
- Fitting a crown to a partial denture clasp
- Biopsies of oral lesions, including those associated with extractions, endodontic or periodontic services
- Skull and facial bone survey films, except when associated with orthodontic benefits
- Saliography
- Temporomandibular joint film and arthrograms
- Imaging of any type
- Bacteriology studies to determine oral health status or pathological agents
- Diagnostic photographs, except when associated with orthodontic benefits
- Histopathological examination
- Mounted case analysis
- Implants, unless otherwise stated
- Sargenti root canal treatment
- Space maintainers for missing front primary teeth
- Repair of a damaged space maintainer or replacement of a lost, stolen or missing one
- Space maintainers provided in connection with orthodontic treatment
- Repair of teeth due to abrasion or attrition
- Procedures to correct birth defects or developmental malformations, such as cleft palate or jaw malformations
- Dental sealants

OTHER BCBSM COVERAGE INFORMATION

1. How to File a Claim

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

To file your own claim, follow these steps:

1. Ask your provider for an itemized statement with the following information:
 - Patient's name
 - Subscriber's name and contract number (from your ID card)
 - Provider's name, address, phone number, and federal tax ID number
 - Diagnosis (nature of illness or injury)
 - Admission and discharge dates for hospitalization

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

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2. Make a copy of all items for your files and send the original to BCBSM. It is important that you file claims promptly because most services have a two-year filing limitation.
 - You will receive payment directly from BCBSM. The check will be in the participant's name, not the patient's name.
 - If you do **not** have Medicare coverage, or if Medicare has already processed the claim, send the claim information to:

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

2. Preventing Fraud

BCBSM tries to prevent fraudulent use of your BCBSM ID card. Only you and eligible dependents are covered for services. A provider of medical services may ask for identification other than the BCBSM ID card. Checking the identification of the cardholder is one way of preventing unauthorized use of your card.

If you think someone is using your card illegally, or that you are being billed for services you did not receive, call the BCBSM Anti-Fraud Hotline:

- In Michigan call (800) 482-3787
- Outside Michigan call BCBSM's Detroit Main Office Customer Service at (313) 225-8100 or (800) 637-2227 and your calls will be transferred to BCBSM's Anti-Fraud Unit.

Calls are toll-free in Michigan and there is a charge outside of Michigan. Your call is strictly confidential.

You may also write to the Anti-Fraud Unit at the following address:

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

You may contact the BCBSM Anti-Fraud Unit online at

- www.bcbsm.com/antifraud/contact.shtml

OTHER BENEFITS PROVIDED BY THE FUND

PRESCRIPTION DRUG BENEFITS

The Fund has engaged Caremark as the administrator of its prescription drug benefit program. You will receive a Caremark prescription drug card, which you and your eligible dependents must present whenever you fill a prescription.

Each time you fill or refill a prescription at a Caremark Participating Pharmacy, you will be responsible for paying the following copayments for up to a 90-day supply:

- Generic Drugs - \$15.00
- Brand Name Drugs - \$30.00

You may use Caremark's mail service program for a 35- to 90-day supply of drugs included on Caremark's list of recognized maintenance drugs for direct delivery to your home. Each time you fill or refill a prescription using Caremark's mail service program, you will be responsible for paying the following copayments:

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- Generic Drugs - \$15.00
- Brand Name Drugs - \$30.00

It is to your benefit to ask your doctor if there is a generic equivalent for any drug prescribed for you and whether it would be appropriate for you instead of the brand name drug.

There are a number of exclusions and limitations related to the Fund’s prescription drug coverage. For example, the Fund’s prescription drug coverage covers the prescription drug Actiq only upon prior approval and only for FDA approved diagnoses. Before having a prescription filled, you should contact Caremark at (800) 241-2784 or www.caremark.com for a specific list of prescription drugs that are not covered or otherwise limited. You should also review “Exclusions and General Limitations” on page 81 of this booklet.

Caremark can also provide you with a list of Caremark Participating Pharmacies. At the time of this printing, the Fund does not cover prescription drugs purchased from Wal-Mart, Sam’s Club or CVS Pharmacy.

Special Notices for Medicare-Eligible Individuals: The Fund’s actuary has determined that the Fund’s prescription drug program is on average at least as good as that being provided by Medicare Part D. This means that if you do not sign up for Medicare Part D now, you will *not* have to pay a higher premium for Medicare Part D if you sign up later.

The Fund will be seeking a financial “subsidy” from Medicare for every eligible participant who does *not* sign up with Medicare Part D. Therefore, the Fund encourages you, if you determine that it is in your best interest to do so, to remain with the prescription drug coverage provided by this Plan and not to sign up for Medicare Part D. If you do decide to sign up for Medicare Part D, your prescription drug coverage with this Fund will be terminated.

Please be alert for special notices regarding the Fund’s prescription drug benefits for retirees and how those benefits relate to benefits provided under Medicare Part D. Please contact the Fund Office if you have questions about retiree prescription drug coverage and/or Medicare Part D.

VISION EXPENSE BENEFITS

The Fund will pay benefits to participants and dependents for the following optical services in the following amounts:

<u>Benefit</u>	<u>Amount of Coverage</u>
Eye Exams once every 12 months	
Ophthalmologist	\$ 50.00
Optometrist	\$ 40.00
Prescribed lenses once every 12 months	
Single	\$ 60.00
Bifocal	\$ 80.00
Trifocal	\$ 90.00
Progressives	\$100.00
Contact Lenses	\$ 90.00
Frames once every 24 months	\$ 70.00
Contact Lenses (in lieu of glasses) (once every 12 months)	\$ 90.00

Claims must be submitted on a form satisfactory to the Trustees with any supporting documentation required by the Trustees within 90 days from the participant’s or dependent’s incurring vision expenses covered by the Plan.

Vision Expense Benefits shall **not** be payable for the following:

- Sunglasses or tinted lenses, unless they are prescribed to be worn at substantially at all times by an ophthalmologist for medical reasons
- Routine yearly examinations required by an employer in connection with the occupation of the individual

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- Vision expenses resulting for occupational bodily injury or disease

LIFE INSURANCE BENEFITS (Active Employees Only)

Life Insurance Benefits are not payable upon the death of dependents or retirees. You may designate as your beneficiary any person or persons you choose. If your beneficiary dies before you, the designation of that individual as beneficiary shall terminate. If you designate your spouse as beneficiary and then are divorced from that spouse, that divorce does **not** terminate the designation of your former spouse as beneficiary. Therefore, if you are divorced and you wish to change your beneficiary, you must designate a new beneficiary by completing the necessary forms which are available at the Fund Office. Even if your divorce decree provides that your former spouse waives rights to your life insurance, you must still complete a new beneficiary card to implement that provision and identify your beneficiary.

If you named two or more beneficiaries, but did not specify a method of sharing the Life Insurance Benefits, the living beneficiaries shall be entitled to equal shares.

You may change your beneficiary at any time by completing the form which is available at the Fund Office.

If you have not named a beneficiary (or if your beneficiary dies before you do and you do not designate a replacement), your Life Insurance Benefits will be paid as follows: to your widow or widower; but if none, to your surviving children in equal shares; but if none, to your surviving parents in equal shares; but if none, to your surviving brothers and sisters in equal shares; but if none, to your estate.

If any beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, the amounts payable to such beneficiary shall be paid to his or her duly appointed guardian. Any such payment shall be for the sole benefit of such beneficiary and shall be a full discharge of the liability of the Fund.

Your survivors must provide proof of your death to the Fund Office within **90 days** after your death.

A Life Insurance Benefit of \$30,000 will be paid to your beneficiary in the event of your death from any cause. An amount not to exceed \$500 may be paid from the \$30,000 Life Insurance Benefit to any person incurring the expense of your burial, provided a receipt is submitted to and determined satisfactory by the Board of Trustees.

If you lose eligibility for Life Insurance Benefits, you may purchase a conversion policy within 31 days from the date of termination. However, if you become disabled for nine (9) months and are under 60, you may have Life Insurance Benefits continued at no cost to you for twelve (12) months or until you are no longer totally disabled, upon application on a form satisfactory to the Trustees. Contact the Fund Office for forms and further information.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Active Employees Only)

Accidental Death and Dismemberment Benefits are not payable upon the death or loss of dependents or retirees. The principal sum, \$30,000, is payable to you, if you lose both hands, both feet, sight of both eyes, one hand and one foot, one hand or one foot and sight of one eye by accidental means.

One-half the principal sum, \$15,000, is payable to you if you lose one hand, one foot or sight of one eye. The maximum amount payable for all losses resulting from one accident is the largest amount payable for any one loss.

You or your survivors must provide proof of your loss to the Fund Office within **90 days** after the accident. Payment will be made regardless of any other benefits you may receive. Your beneficiary for purposes of Accidental Death and Dismemberment Benefits will be determined in the same manner as for purposes of Life Insurance Benefits.

Payment shall **not** be made under this provision for any loss resulting from or caused directly or indirectly, wholly or partly by:

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- Bodily or mental illness or disease of any kind, ptomaine, bacterial infections (except pyogenic infections which shall occur with and through accidental cut or wound);
- Suicide or attempted suicide or intentional self-inflicted injury, while sane or insane;
- Participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion; or
- War or act of war, whether declared or undeclared; any act related to war or insurrection; service in the armed forces of any country while such country is engaged in war; or police duty as a member of any military, naval or air organization.

WEEKLY DISABILITY BENEFITS (Active Employees Only)

If you are eligible for benefits and are unable to work because of an accident occurring **off** the job, an accident **not** involving an automobile or other motor vehicle licensed to be on the road, or any illness **not** connected with employment, you will be entitled to Weekly Disability Benefits for a maximum of 26 weeks or the period of your disability, whichever is shorter. If you remain wholly and continuously disabled, you may receive an additional 13 weeks of Weekly Disability Benefits, for a maximum of 39 weeks of Weekly Disability Benefits. The weekly benefit is \$250 for journeymen and \$175 for allied tradesmen. Payment for one day of disability is 1/7th of the amount of the weekly benefit.

If you have an occupational-related disability, you are not entitled to Weekly Disability Benefits.

Benefits are payable from the first day of disability due to an injury or accident, from the first day when confined to a hospital and from the first day following surgery in an outpatient department of a hospital. Benefits are payable from the eighth day of disability due to an illness and pregnancy.

You will not be eligible for a new Weekly Disability Benefit period for disability due to the same or related causes until you have returned to work for an employer on a full-time basis for at least two weeks. Under no circumstances will you be eligible for more than 26 weeks of Weekly Disability Benefits (or 39 weeks, if applicable), whether received during one or more Weekly Disability Benefit periods, as a result of a disability due to the same or a related cause.

In determining when one disability period ends and a new period begins, all disability absences due to the same or related causes and separated by less than 14 days of active work will be considered as occurring in a single disability period. If a new disability period is due to a cause different from the causes of any prior disability, it must be separated from the prior disability by 14 days of full-time active work in order for the eligible participant to be eligible for payment for that absence. No period of disability will be considered as beginning more than three days prior to the first medical visit or treatment.

Benefits are not payable during a strike unless the disability commenced prior to the strike and while you were still actively employed.

You must file a Weekly Disability Benefits claim form with the Fund Office within 20 days after the first day of disability and submit written proof that you are disabled before benefits will be paid. You must also file a claim form to apply for the additional 13 weeks of coverage if you are wholly and continuously disabled.

You will be required to complete IRS Form W-4 at the Fund Office, and federal income tax and Social Security taxes will be withheld from your Weekly Disability Benefit payments. You will receive an IRS Form W-2 from the Fund Office by January 31 of the year following the year in which you received Weekly Disability Benefits for your use in filing your income tax return.

Weekly Disability Benefits are **not** payable:

- For any day during which the eligible participant has performed any work, anywhere, for pay or profit.

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- For any period during which the eligible participant is not under the care of a legally qualified physician.
- In the event an eligible participant is disabled as a result of an automobile accident.
- In the event that an eligible participant is eligible for loss-of-time/weekly disability benefits from another plan, provided such benefits are equal to those provided by this Plan.
- For disability due to accidental bodily injuries arising out of and in the course of such eligible participant's employment or a disease for which the eligible participant is entitled under the applicable Workers' Compensation Law, Occupational Disease Law or similar law.
- While maintaining your eligibility by using your Hourly Reserve Bank or by self-payment.

CLAIMS APPLICATIONS, LIMITS AND APPEALS

1. Applying for Benefits and Time Limits for Claims

Claim forms for benefits covered by the Fund's agreement(s) with BCBSM are available from BCBSM, and all such forms and supporting documentation must be submitted to BCBSM and in conformity with the requirements of BCBSM, including all time limits and proofs. The documentation should include the patient's name; the participant's (subscriber's) name and contract number from your BCBSM card; the provider's name, address, phone number and federal tax ID number; date and description of services, diagnosis (nature of illness or injury) and admission and discharge dates for hospitalization. The claim documentation should be sent to Blue Cross/Blue Shield of Michigan, General Groups Service Center, Mail Code **X410**, 600 E. Lafayette Blvd., Detroit, MI 48226.

The Fund has no liability for any claim determination made by BCBSM. If a claimant disagrees with a determination made by BCBSM, he must appeal directly to BCBSM and comply with BCBSM's claims appeal process. Claims for medical, hospital and surgical services provided by BCBSM-related providers should be submitted by the provider directly to BCBSM. Providers who do not participate with BCBSM may also agree to submit their claims directly to BCBSM, but if they will not, contact the BCBSM to submit your claims directly to it.

If you submit claims directly to BCBSM, they must be submitted within the following time limits:

- **Medical, Hospital and Surgical Benefits** - Claims for hospital and facility charges must be submitted within 18 months. Claims for charges for professional services (such as physician charges) must be submitted within 15 months.
- **Dental Expense Benefits** – Claims for dental expense benefits must be submitted within 24 months.

Claim forms for benefits **not** covered by the Fund's agreement(s) with BCBSM are available from the Fund Office and all such forms and supporting documentation must be submitted within the following time periods established by this Plan for such benefits. Those benefits and time periods are as follows:

- **Prescription Drug Benefit** claims must be submitted within 90 days for claims made by the pharmacy and within 270 days from the fill date for paper claims
- **Life Insurance Benefit** claims must be submitted within 90 days from the eligible individual's death
- **Accidental Death and Dismemberment Benefit** claims must be submitted within 90 days from the Active Employee's loss or death
- **Weekly Disability Benefit** claims must be submitted within 20 days from the onset of the Active Employee's disability

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- **Vision Expense Benefit** claims must be submitted within 90 days from the participant's or dependent's incurring vision expenses covered by the Plan

If processing of a claim cannot be completed because of missing information, the Fund Office will notify the claimant and advise him or her of the specific reason why the processing of the claim cannot be completed and what information is necessary to permit the processing of the claim to continue. It is the claimant's responsibility to gather this information and submit it within the required time period.

If a claim for benefits under this Plan is completely or partially denied by the Fund Office, the Fund Office will notify the claimant and advise him or her of the specific reasons for denial. Notice of denial will normally be sent within 90 days after the claim has been received by the Fund Office. In a few unusual circumstances, the Fund Office may require additional time to process the claim, in which case it will notify the claimant that additional time is required to process the claim and the date on which it expects to make a final decision. The Fund Office may take as long as 90 additional days to complete the processing the claim.

Late proof may be accepted only if, under the particular circumstances, it was furnished as soon as was reasonably possible, and, in any event except in the absence of the claimant's legal capacity, within two years after the time it was otherwise required.

*Any action in law or equity brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to the Plan shall be barred unless the complaint is filed within **two years** after the right of action therefor accrues, unless a shorter period is established by applicable statute, regulation or case law.*

2. Denial of Claims

If your claim is denied, you will normally be notified with the specific reason for denial within 90 days. In unusual circumstances, additional time will be required to process your claim. You will be notified when additional time is needed.

If your claim is denied by BCBSM or another Fund service provider, you will be informed of the reason for the denial on the "Explanation of Benefits" you receive. If the denial is due to missing information or a missing signature, you should supply the information directly to the service provider. If the denial is due to any other reason and you believe that the claim should have been covered, you should follow the procedure set out below for appealing a denial of your benefit claim.

3. Appealing a Denial of Your Benefit Claim

Every effort is made to process your claims promptly and correctly. If your claim for benefits is denied in whole or in part, BCBSM or the Fund Office will notify you of the denial in writing. To appeal the denial or payment, you must follow these steps:

A. Appeals Regarding Medical, Hospital and Surgical and Dental Benefits

Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved through a phone call to one of BCBSM's 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 BCBSM sends to notify you that BCBSM has not approved a request for benefits.

In addition, the Employee Retirement Income Security Act of 1974, as amended, (ERISA) claims procedure regulations and Michigan Public Act 350 of 1980, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protect you by providing you the opportunity to request review of an adverse benefit determination.

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make

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payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in the Michigan Glass & Glazing Industry Welfare Insurance Fund. You should request review of adverse benefit determinations by BCBSM on a pre-service claim, an urgent care claim, or a post-service claim directly to BCBSM, except denials based on your eligibility to participate in the Fund, in which case you should direct your request for review to the Fund Office.

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

A claim will be found to be one involving urgent care in one of two ways. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, BCBSM will treat it as such. Absent a determination by your physician, BCBSM 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, a post-service, or an urgent care claim.

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

BCBSM INTERNAL REVIEWS

Standard Internal Review Procedure – Post-service claims

Under the standard internal review procedure for post-service claims, BCBSM must provide you with its final written determination within 35 calendar days of BCBSM’s receipt of your written request for review. However, that timeframe may be suspended for any amount of time that you are permitted to take under the review procedure, and for a period of up to 10 days if BCBSM has not received information from a health care provider, for example your doctor or hospital.

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 BCBSM a written statement explaining why you disagree with BCBSM’s 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 BCBSM’s decision on your claim for benefits**. 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 contained in the letter BCBSM sends you to notify you that BCBSM has not approved a benefit or service you are requesting. BCBSM will respond to your request for review in writing within 21 days. If you agree with BCBSM’s response, it becomes BCBSM’s final determination and the review ends.
2. If you disagree with BCBSM’s response to your request for review at level 1, you may then

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proceed to level 2 by requesting a managerial-level conference. Again, please provide all documentation, records, and comments that you feel support your position. 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, MI 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 BCBSM's headquarters in Detroit or at a local customer service center. BCBSM will provide you a written proposed resolution within the time period allowed under the law. BCBSM's written proposed resolution will be its final determination regarding your request for review.

3. If you disagree with BCBSM's final determination, or if BCBSM fails to provide it to you within 35 days of the date BCBSM received your original written request for review (plus any time you may have taken under the review procedure or that BCBSM was allowed to take to obtain information from your provider), or otherwise fails to comply with the review procedures for level 1 or level 2, you have the option to request an external review from the Michigan Commissioner of Financial and Insurance Services. The procedures for this voluntary external review are explained below under the heading, "Standard External Reviews." In addition to the option of requesting external review, you also have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

Standard Internal Review Procedure – Pre-service claims

1. The standard internal review procedure for pre-service claims is identical to the standard internal review procedure for post-service claims, except that BCBSM must provide you with a final written determination within 30 calendar days of BCBSM's receipt of your written request for review. The 30 days will be divided as follows. BCBSM will issue its determination within 15 days of receipt of your request for a level 1 review, and within 15 days of your request for a level 2 review.
2. If you disagree with BCBSM's determination at level 2, or if BCBSM fails to issue its determination within 30 calendar days or otherwise fail to comply with the review procedures for level 1 or level 2, you have the option to request a Standard External Review. In addition to the option to request a Standard External Review, you also have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

Standard Internal Review Procedure – Urgent care claims

The standard internal review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call BCBSM Customer Service at (313) 225-8100 or (800) 637-2227.
2. BCBSM must provide you with its decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including BCBSM's decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If BCBSM's decision is communicated orally, BCBSM must provide

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you or your authorized representative with written confirmation of BCBSM's decision within two business days.

3. If you disagree with BCBSM's final determination, or if BCBSM fails to provide it to you within 72 hours of the date BCBSM received your grievance, or otherwise fails to comply with the review procedures, you have the option to request an expedited external review from the Michigan Commissioner of Financial and Insurance Services. Your request must be made within 10 days of receiving BCBSM's final determination. The procedures for this voluntary external review are explained below under the heading, "Expedited External Reviews." In addition to the option of requesting external review, you also have the right 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:

- You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure.
- No fees or costs may be imposed as a condition to requesting review.
- Although there are set timeframes within which you must receive BCBSM's final determination on all three types of claims, you have the right to allow BCBSM additional time if you wish.
- You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.
- The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.
- If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.
- Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.
- On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.
- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment

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or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.

- If your health plan provides for any voluntary appeal procedures beyond the level 2 review, you will be advised of those procedures in the level 2 response.

BCBSM EXTERNAL REVIEWS

Standard External Review Procedures

Once you have exhausted BCBSM's standard internal review procedure, you or your authorized representative has the right to request an external review from the Commissioner of Financial and Insurance Services. The standard external review process that applies to pre-service or post-service claims is as follows:

1. Within 60 days of the date you either received BCBSM's final determination or should have received it, send a written request for an external review to the Commissioner. Mail your request, including the required forms that BCBSM will supply to you, to:

Michigan Division of Insurance
Benefit Inquiry Section
Post Office Box 30220
Lansing, MI 48909

2. If your request for external review concerns a medical issue and is otherwise found to be appropriate for external review, the Commissioner will assign an Independent Review Organization, consisting of independent clinical peer reviewers, to conduct the external review. You will have an opportunity to provide additional information to the Commissioner within seven days after you submit your request for an external review. BCBSM must provide documents and information considered in making its final determination to the Independent Review Organization within seven business days after BCBSM receives notice of your request from the Commissioner. The assigned Independent Review Organization will recommend within 14 days whether the Commissioner should uphold or reverse BCBSM's determination. The Commissioner must decide within seven business days whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.
3. If your request for external review is related to non-medical issues, and is otherwise found to be appropriate for external review, the Commissioner's staff will conduct the external review. The Commissioner's staff will recommend whether the Commissioner should uphold or reverse BCBSM's determination. The Commissioner will notify you of the decision, and the Commissioner's decision is your final administrative remedy under Public Act 350.

Expedited External Review Procedure

If your request for external review involves an urgent care claim, and if you have filed a request for an expedited internal grievance, you may request and expedited external review from the Commissioner. The expedited external review process is as follows:

1. Within 10 days of your receipt of BCBSM's denial, termination, or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Commissioner of Financial and Insurance Services. To do so in writing, mail your request, including the required forms that BCBSM will supply to you, to:

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Michigan Division of Insurance
Benefit Inquiry Section
Post Office Box 30220
Lansing, MI 48909

To do so by telephone, call the following toll free number: (877) 999-6442.

2. Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and assign an Independent Review Organization to conduct the expedited external review. If the Independent Review Organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse BCBSM's determination. The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

Note: If you are dissatisfied with the Commissioner's decision on a Standard or Expedited External Review, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

Section 402 and 403 of Public Act 350

What BCBSM May Not Do

The sections below provide the exact language in the law. Section 402(1) provides that BCBSM 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 claim for which liability has become reasonably clear.
- Compel BCBSM 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 BCBSM member a policy of appealing from administrative hearing decisions in favor of BCBSM members for the purpose of compelling a BCBSM member to accept a settlement or compromise in a claim.
- Attempt to settle a claim on the basis of an application that 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 BCBSM member, or the provider of health care services to the BCBSM 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.

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- 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 BCBSM 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 BCBSM cannot do under this section are:

- Issue or deliver to a person or 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 thereunder, 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 BCBSM Must Do

Section 403 provides that BCBSM 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 BCBSM has 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 time of payment of the claim. BCBSM must specify in written the materials which constitute a satisfactory claim form no later than 30 days after receipt of the 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 BCBSM receives the claim form.

Disclosure Required by the Patient Protection Act

Upon enrollment, BCBSM must provide subscribers, in plain English, a written description of the terms and conditions of Blue Cross/Blue Shield of Michigan's certificate. The form must list all information that is available to the individual upon request. The following information is available to you upon request by phone or in writing to BCBSM Customer Service at (313) 225-8100 or (800) 637-2227, Blue Cross/Blue Shield of Michigan, 600 Lafayette East, Mail Code X410, Detroit, Michigan 48226:

- A description of the current provider network in your service area
- A description of the professional credentials of participating health professionals
- The licensing verification telephone number for the Michigan Department of Consumer and Industry Services
- A description of any prior authorization requirements and any limitations, restrictions, or exclusions
- A description of financial relationships between the Blue Cross/Blue Shield of Michigan managed care areas and any closed provider network. BCBSM requires that your request for information be submitted in writing.

B. Appeals Regarding Eligibility Determinations, Prescription Drug Benefits, Life Insurance Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits and Vision Expense Benefits

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You may appeal a denial of a claim related to an eligibility determination or a claim for **Prescription Drug Benefits, Life Insurance Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits and/or Vision Expense Benefits** by writing out the reasons for your disagreement and the facts on which you rely for your claim to benefits and mailing your appeal **within 180 days of the notice of denial** to the Board of Trustees, Michigan Glass & Glazing Industry Welfare Insurance Fund, P.O. Box 966, Troy, MI 48099-0966. No special form is required. Just be sure that what you have written explains your position as clearly as you can state it. You have the right to appoint someone else (such as a lawyer) to prepare and submit your appeal to the Fund. Make sure your name, the last four digits of your social security number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

The claimant or the claimant's authorized representative on the claimant's behalf, will have the opportunity to review pertinent documents and other information relevant to the claim free of charge if you submit a written request. Reasonable access to, and copies of, relevant information will be provided upon request. Whether information or a document is "relevant" is determined in accordance with ERISA Regulation §2560.503-1(m)(8), 29 CFR 2560.503-1(m)(8).

When a claimant's appeal is received, it will be reviewed "de novo" (meaning "anew" and without deferring to the initial denial of your claim) and additional materials and information you submit with the appeal, if any, will also be reviewed.

The claimant, or the claimant's representative, may submit issues, comments, additional legal arguments and new information in writing consideration in the appeal. The review of the appeal will take into account all materials and information received from **before** the review and decision on your appeal, whether or not that information was previously submitted or considered in the initial determination on the claim.

The Board of Trustees will respond to appeals of denials of claims regarding eligibility and for benefits not administered by BCBSM in the following timeframes: no later than 72 hours after receiving an appeal of a denial of a **pre-service urgent care claim**, no later than 30 days after receiving an appeal of a **pre-service non-urgent care claim**, and no later than five days after the Board of Trustees' first regularly scheduled meeting following receipt of your appeal of a claim for **post-service care**, unless your appeal is filed less than 30 days prior to such meeting, in which case it will be reviewed at the subsequent Board of Trustees' meeting. (Denials of claims for benefits administered by BCBSM are addressed in the prior section.)

The claimant may request a personal appearance before the Board of Trustees, which they may grant or deny at their sole and exclusive discretion. Such a request must be made in writing. He may designate someone of his choice to represent him or her at such an appearance at his own expense.

If, due to special circumstances, the Board of Trustees requires additional time to review an appeal of a claim for post-service care, the claimant will be notified in writing of the special circumstances and when a determination will be made. The Board of Trustees will communicate its decision and the reasons for the decision in writing within five days after they make their decision on your appeal.

You will be notified, in writing, of the Board of Trustees' decision with respect to your appeal, including (if your appeal is denied) the reasons and specific references to Plan documents upon which the Board of Trustees' decision was based.

The Board of Trustees has the sole and exclusive discretion to interpret and to apply the rules of the Plan, the Trust and other rules and regulations. Please note that under the law, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless the complaint is filed within **two years** after the right of action accrues, unless a shorter time period is established by applicable statute, regulation or case law. You should seek legal advice with respect to these requirements.

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CIRCUMSTANCES WHICH CAN RESULT IN DENIAL OF OR LOSS OF BENEFITS

The Board of Trustees or its representatives have the authority to deny payment for claims, and the reasons for denial may include one or more of the following:

- The person receiving the benefit was not eligible for benefits on the day the expense was incurred. This includes a former spouse or any person no longer eligible as a dependent when an expense was incurred.
- The claim was not received by the Fund within the required time period.
- The expense was for services not covered by the Fund or the expense was not actually incurred.
- The person for whom the claim was filed already received the maximum benefit for the type of benefit; for example, a lifetime maximum, a Benefit Year maximum, etc.
- The person for whom the claim was filed had not yet satisfied any required copayment imposed by the Fund.
- The person for whom the claim was filed (or another person on their behalf) failed to sign the Fund's subrogation agreement, failed to cooperate with the Fund's right of reimbursement or failed to remit the Fund's reimbursable amount from a recovery, including a partial recovery (in which case, future claims will be denied up to the amount of the Fund's reimbursable amount).
- Another entity was primarily responsible for paying benefits (see the Fund's rules on coordination of benefits).
- The Fund was terminated.

The above list does not list every reason a claim may be denied. It is only representative of the types of circumstances that might lead to a denial of a claim. If you have questions about a claim denial, contact the Fund Office.

ADDITIONAL ADMINISTRATIVE MATTERS

PAYMENT OF BENEFITS

Benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefits shown in this booklet according to the following provisions:

- All bills from hospitals and doctors who participate with BCBSM will automatically be sent to BCBSM which pays the Fund's share of the expenses to the hospital or doctor directly to them. You will receive an "Explanation of Benefits" ("EOB") from BCBSM telling you what has been paid. You are responsible for paying any amount remaining due.
- Generally, bills from hospitals and doctors who do not participate with BCBSM and some other service providers will be sent directly to you. You may then file a claim at the Fund Office.
- When you receive an EOB from BCBSM, please review it carefully. There may be additional amounts payable by the Fund which have been excluded. Contact the Fund Office with questions in this regard.
- In determining the satisfaction of any copayment amount, a charge for any service will be considered to have been incurred on the date that the service was provided to the patient.
- If a person is not mentally, physically or otherwise able to handle his/her business affairs, the Fund may pay benefits to the legally appointed guardian or conservator, or if none, to the individual who has assumed responsibility for the person's primary care and maintenance. If the person dies and the Fund owes benefits, the Fund may make payments to the estate, surviving spouse, parents, child or children or to any individual that the Board of Trustees determines, in its sole discretion, is entitled to the benefits.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

- Any payment made by the Fund in accordance with these provisions will fully discharge the Fund's liability to the extent of the payment.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

EXAMINATIONS

The Board of Trustees has the right to ask a doctor of its choice to examine a person for whom benefits are being claimed. It also has the right to examine any and all hospital or medical records relating to a claim.

TRUSTEE INTERPRETATION AND AUTHORITY

Under the terms of the Plan and the Trust establishing the Fund, the Board of Trustees has the sole authority to interpret and apply the rules of the Plan, the Trust and any other rules and regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Board of Trustees or, where Board of Trustees' responsibility has been delegated to others, its delegates, will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees or its authorized delegates is challenged in court, the Trust Agreement and the Plan provide that such decision is to be upheld unless a court with proper jurisdiction finds and issues a decision that it was arbitrary and capricious.

All benefits under the Plan are subject to the Board of Trustees' authority under the Trust Agreement to change them. The Board of Trustees has the authority to increase, decrease, change, amend and terminate benefits, eligibility rules or other provisions of the Plan as it may determine to be in the best interests of the Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted to a participant under the Plan are legally enforceable.

The right to change or eliminate any and all aspects of benefits provided for retirees and their dependents is a right specifically reserved to the Board of Trustees, since coverage for retirees and their dependents, like all of the benefits from the Fund, is not an accrued or vested benefit. The Board of Trustees has the authority to amend or terminate such benefits and to modify or increase the self-payment amount for coverage at any time. Any such change shall be effective even though an employee has already become a retiree, or has met the eligibility requirements to retire now or in the future.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation law, occupational diseases law or similar law. Benefits which would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

PLAN DISCONTINUATION OR TERMINATION

The Fund and its Plan may be discontinued or terminated under certain circumstances - for example, if future collective bargaining agreements and participation agreements do not require contributions to the Plan. In such event, benefits for covered expenses incurred by the termination date will be paid on behalf of eligible participants and their dependents as long as the Fund's assets are more than its liabilities. Full benefits may not be paid if the Fund's liabilities are more than its assets, and benefit payments will be limited to the funds available. The Board of Trustees will not be liable for the adequacy or inadequacy of such funds. If there are any assets remaining after payment of Fund liabilities, those assets will be used for purposes determined by the Board of Trustees according to the Trust Agreement.

RIGHT OF OFFSET

If any payment is made by the Fund to or on behalf of a person who is not entitled to the payment or to the full amount of such payment, the Fund has the right to reduce future payments to that person or to the person responsible for the erroneous payment by the amount of the erroneous payment. This right of offset will not limit the right of the Fund to recover such erroneous payments in any other manner.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

LEGAL ACTIONS - TIME LIMITS

You may not file legal action against the Fund or its Trustees to recover loss until all of the proper claim and claim appeal procedures have been followed by you. In addition, any action in law or equity brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to the Plan shall be barred unless the complaint is filed within two years after the right of action therefor accrues, unless a shorter period is established by applicable statute, regulation or case law. You should seek legal advice if you have questions on this matter.

ALTERED OR FORGED CLAIMS

Any claim form or other materials submitted by or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Board of Trustees reserves the right to forward such matters to appropriate law enforcement agencies for whatever action deemed appropriate. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any manner.

NOTICE OF HOURS WORKED

Each month the Fund Office will mail you a statement listing the hours that you worked. This report provides you with a summary of hours worked during the most recent month so that you may compare the Fund's records to your pay stubs.

You must report any discrepancy to the Fund Office immediately. If the discrepancy is the result of overlapping payroll periods and eligibility is adversely affected, the Fund Office will process an eligibility adjustment after you submit copies of pay stubs and/or other verification establishing that different payroll periods caused an overlapping of hours.

If your employer fails to remit contributions based on your work, the Fund will pursue collection, but you are responsible for maintaining your coverage by self-payment. If the Fund recovers some or all of the unpaid contributions, your self payment amounts will be refunded to you based on the extent of the recovery.

SPECIAL PROVISIONS FOR PARTICIPANTS AGE 65 AND OLDER

1. Medicare

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

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

Medicare Part A is hospital insurance helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Medicare Part B is medical insurance helps pay for physician's services and other medical services and items. Medicare Part D plans help pay for prescription drug coverage.

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

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You must enroll for Medicare Parts A and B and pay all premiums immediately when you reach age 65, even if you are still working, but you are not required by this Plan to enroll for Medicare Part D coverage. In those cases where Parts A or B of Medicare and the Fund cover the same items or services, the Fund will pay first and then Medicare will supplement the Fund's coverage up to the Medicare limits. In most cases, the Fund's benefits are more generous than those provided under Medicare. Where they are not, you retain the right to file your claim with Medicare for whatever supplemental coverage is available. Your combined benefits from Medicare and the Fund will remain unchanged even though the Fund, rather than Medicare, is the primary payer.

You should not forget to continue to pay the Part "B" Medicare premium for medical services for your own protection. Failure to pay the Part "B" premium on time will result in the loss of Medicare protection for medical services. However, if you are working at age 65, you may be able to delay enrollment in Medicare Part "B", without a penalty, until you stop working.

Special Notice Regarding Medicare Part D: If you are eligible for Medicare, you should be receiving a special notice regarding the Fund's Prescription Drug Benefits and how those benefits relate to prescription drug benefits available under Medicare Part D. Please contact the Fund Office if you have questions regarding retiree prescription drug coverage under this Plan and/or Medicare Part D.

If you enroll in Medicare prescription drug coverage, you will lose your prescription drug coverage with the Michigan Glass & Glazing Industry Welfare Insurance Fund. The Michigan Glass & Glazing Industry Welfare Insurance Fund will not provide prescription drug coverage for participants who enroll in Medicare prescription drug coverage. If you enroll in the Medicare prescription drug program, the Michigan Glass & Glazing Industry Welfare Insurance Fund will continue to provide you with your other non-prescription health benefits.

2. Employed Persons Aged 65 or Older

If you are eligible by way of hours worked in covered employment and you continue to work beyond the date you become eligible for Medicare (age 65), you have two options for health care coverage:

Option 1: Continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue this coverage.

Important: If you continue to be covered through the Michigan Glass & Glazing Industry Welfare Insurance Fund for your primary health care benefits, **you should still apply for Medicare benefits, especially Part A.**

- Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide **additional** benefits to your group coverage.
- Part B of Medicare, the medical insurance, is available for a monthly premium. However, you can delay enrollment in Part B without penalty.

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

You do not need to enroll in Medicare Part D coverage, as explained in the prior section .

Option 2: Select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibit the Fund from providing you with Supplemental coverage. You must file a written notice with the Fund Office and with Medicare if you choose this option.

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

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

3. Retired Persons Aged 65 or Older

When, after age 65, you cease active employment, Medicare shall automatically become the primary payer after your eligibility by way of hours worked in covered employment runs out, and the Fund will be secondary.

DEPENDENTS ON MEDICARE

If you are eligible by way of hours worked in covered employment, the Fund will be the primary payer of benefits to your dependent who is on Medicare because of age or disability. Also, special rules apply to a person with end stage renal disease (ESRD) under Medicare. Check with the Fund Office or your local Social Security office for additional information on this.

COORDINATION WITH MEDICAID

If you or your dependents are entitled to Medicaid at the same time you are eligible for benefits from the Fund, the Fund will be the primary payer of benefits.

COORDINATION OF BENEFITS/NON-DUPLICATION OF BENEFITS

Coordination of benefits provisions come into play whenever an eligible person has other coverage under any health care plan, fund, group insurance program, Medicare, or any statute (law).

Under these provisions, the Fund will pay the benefits in accordance with its applicable Schedule of Benefits if it is considered to be primary. Otherwise, the other plan, fund, program, etc., will be required to pay the benefits up to the maximum amount payable in accordance with its Schedule of Benefits and the Plan will then pay any remaining amounts not otherwise covered up to and in accordance with its Schedule of Benefits so that, in the aggregate, no more than 100 percent of the incurred covered expenses will be paid.

The Fund will not duplicate benefits paid to you or your dependents under another health care plan, fund, policy, contract, program or statute. Benefits from the Fund are subject to, and limited to, benefits payable in accordance with these coordination of benefits provisions. Coordination of benefits provisions are rules which determine the order in which two or more plans which may be covering you or your dependents pay benefits first, so that benefits will be paid up to but not to exceed 100 percent of the allowable expenses on the claim. These rules apply to every eligible person covered by the Plan and to all benefits payable under the Plan, **except** Life Insurance Benefits and Accidental Death and Dismemberment Benefits.

This Plan **excludes** coverage and will pay **no** benefits for treatment of injuries resulting from an automobile or motor vehicle accident (except as otherwise stated in the Fund's insurance policy with BCBSM). *You should carefully review this with your automobile or other motor vehicle insurance carrier to make certain that your own insurance is adequate in this regard.*

Generally speaking, the following rules are applied to determine whether the Michigan Glass & Glazing Industry Welfare Insurance Fund or the other health care plan, fund, policy, contract, program, or statutory payer pays first in accordance with its Schedule of Benefits.

- A. If the other plan, fund, policy, contract, program, or statutory payer has not adopted a coordination of benefits provision, it shall be required to pay first.
- B. If both have coordination of benefits provisions, then
 - (i) the plan in which the eligible person is covered as an employee shall pay in accordance with its Schedule of Benefits as primary. The plan in which the eligible person is covered as a dependent shall pay secondary up to its maximum Schedule of Benefits.

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- (ii) where the claim is for an eligible dependent child, the following order of priority shall be followed in determining which plan, fund, policy, contract, program or statutory payer shall pay first:
 - (a) the plan covering the child's parent who has the earlier birthdate anniversary in the calendar year shall be primary;
 - (b) if both parents have the same birthdate, the plan which covered the child for the longer period of time shall be primary;
 - (c) if the child's parents are divorced, or legally separated, the plan covering the parent who is financially responsible for the health care of the child pursuant to court decree shall be primary. If there is no court decree, the plan covering the custodial parent shall be primary. If the custodial parent is remarried, the plan covering the spouse of the custodial parent is primary over that which covers the non-custodial parent.

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

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

Blue Cross/Blue Shield of Michigan
COB Department, Mail Code B570
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Please **make copies of all forms and receipts** for your own files, because Blue Cross/Blue Shield cannot return the originals to you.

Updating COB Information – Your Responsibility: It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify the Fund Office immediately. The Fund Office and/or BCBSM may periodically ask you to update your COB information. Please help BCBSM serve you better by responding to requests for COB information quickly.

SUBROGATION AND REIMBURSEMENT

In the event of any payments of services to or on behalf of any person under this Plan, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery of that person (or his representative(s)) arising out of any claim or cause of action which may accrue against any third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. That person (or his representative(s)), by acceptance of benefits provided by this

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Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees, that person (or his representative(s)) may owe, and before that person (or his representative(s)) pays any other individual, organization or entity out of that full or partial recovery (i.e., the Fund has first priority with respect to its rights under this provision). Such monies recovered shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds those monies. That person (or his representative(s)) may take no action which would prejudice the Fund and/or any of the Fund's designees' rights, and that person (or his representative(s)) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Board of Trustees may require to facilitate the enforcement of the Fund's rights. The Fund and/or any of the Fund's designees will not be responsible for attorney's fees or costs incurred and/or paid by or on behalf of that person (or his representative(s)) unless the Fund and/or any of the Fund's designees has agreed in writing to pay such fees or costs or some portion thereof.

If the Fund and/or any of the Fund's designees pays benefits on behalf of any person and that person (or his representative(s)) receives a settlement that person (or his representative) must repay the Fund and/or any of the Fund's designees up to the amount of benefits it/they have paid. If that person (or his representative(s)) does not do so, the Fund and/or any of the Fund's designees has the right to treat the amount of benefits paid and not recovered as (1) a debt of that person (or his representative(s)) to the Fund and/or any of the Fund's designees and may pursue recovery of said amount from that person (or his representative(s)); (2) an advance on future claims payable on behalf of that person (or his representative(s)); or (3) an amount held by that person (or his representative(s)) in constructive trust on behalf of the Fund.

RESTITUTION WHERE BENEFITS IMPROPERLY RECEIVED

The Fund and its Trustees shall have the right to pursue restitution from any person who receives benefits of any description from the Fund to which such person was not entitled, whether by virtue of the ineligibility of such person at the time services were rendered, by virtue of receipt of excluded benefits or otherwise.

EXCLUSIONS AND GENERAL LIMITATIONS

Except as may be provided under the Fund's agreements with BCBSM or specifically provided for under the terms of the Plan, the Plan shall not provide benefits for the following, except Life Insurance Benefits and Accidental Death and Dismemberment, unless otherwise noted:

The Plan will NOT provide for treatment of injuries sustained in an automobile accident or other motor vehicle licensed to be on the road or complications resulting for such injuries or accident. The Plan will NOT provide Weekly Disability Benefits if you are unable to work because of an accident involving an automobile or other motor vehicle licensed to be on the road.

The Plan will NOT provide for treatment of injuries resulting from causes other than sickness, accidental injury or disease. However, the Plan will provide for treatment of injuries resulting from domestic violence. The Trustees may require details describing the incident, including a copy of the police report where available.

The Plan will NOT provide for expense incurred if the person is engaged in any unlawful act.

The Plan will NOT provide for benefits for injuries that you receive while working for pay or profit.

The Plan will NOT provide for loss or expense from sickness, or disease which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law, or as a result of any accidental bodily injury which arises out of or in the course of employment. The Plan will NOT provide Weekly Disability Benefits if you are unable to work because of an accident occurring on the job or an illness connected with employment.

The Plan will NOT provide for services that would not be charged if there were no insurance.

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The Plan will **NOT** provide for services for which a charge is not customarily made, services for which the patient is not obligated or services available without cost.

The Plan will **NOT** provide for treatment of a condition caused by military action or war or determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

The Plan will **NOT** provide for care and services available at no cost in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency.

The Plan will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare or TRICARE. However, the Plan will provide for prescription drugs that are payable by a Medicare Part D prescription drug plan.

The Plan will **NOT** provide for payment of surcharge or non-resident tax levied by community hospitals, except where required by law.

The Plan will **NOT** provide for medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location.

The Plan will **NOT** provide for services and supplies that are not medically necessary according to accepted standards of medical practice (including cosmetic surgery solely for improving appearance), except that coverage will be provided for reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast for symmetrical appearance and prostheses and physical complications in all stages of mastectomy.

The Plan will **NOT** provide prescription drug coverage for age-related appearance or weight loss purposes.

The Plan will **NOT** provide for services, care, devices or supplies considered experimental or investigative.

The Plan will **NOT** provide for hospital care and medical services and supplies provided **prior** to the effective date of coverage or **after** the coverage termination date.

The Plan will **NOT** provide for the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.

The Plan will **NOT** provide for charges for hospital rooms in excess of the hospital's regular charges.

The Plan will **NOT** provide for television, telephone, guest trays or other non-essential personal items and services, including take-home prescription drugs and supplies.

The Plan will **NOT** provide for court ordered hospital confinements and treatment required by court orders, which is the result of an order of any court of law to any participant or dependent, even when prescribed by a physician.

The Plan will **NOT** provide for comprehensive nutritional programs or for visits with specialists in endocrinology and visits when required solely for the purpose of weight loss or for treatment of obesity only or for expense incurred for dietary supplements and nutritional lectures and quick weight loss programs and clinics.

The Plan will **NOT** provide for installation of air conditioning units, sun lamps, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences even when prescribed by a physician, including ergometers, exercycles, bicycles, etc.

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The Plan will **NOT** provide for psychological tests for vocational guidance or counseling.

The Plan will **NOT** provide for hospital confinement or medical expense due to pregnancy of dependent children.

The Plan will **NOT** provide for expense incurred for family planning, semen analysis, fertility and infertility analysis and diagnostic expense or in vitro-fertilization or artificial insemination.

LEGAL NOTICES

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). "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. However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at 700 Tower Drive, Suite 300, P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending provider and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, for Active Employees and Retirees under age 65, and their families, the Fund generally pays 100 percent of the approved amount for these services when provided by CMM-PPO network providers at CMM-PPO network hospitals.

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If you would like more information on WHCRA benefits, contact the Fund Office at 700 Tower Drive, Suite 300, P.O. Box P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957.

NOTICE OF ERISA RIGHTS

As a participant in the Michigan Glass & Glazing Industry Welfare Insurance Fund, 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 Fund office and at other specified locations, such as worksites and the union hall, all Plan documents including collective bargaining agreements and copies of all documents filed by the Fund with the United States Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Board of Trustees, the Plan Administrator. The Fund will, however, make a reasonable charge established by the Trustees for furnishing the copies.
- Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of the summary annual report.
- 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. See page 16 of this booklet (summary plan description) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of the exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage for another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a 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 Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

Enforce Your Rights

No one, including your employer, the union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you may be entitled or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the 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

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Fund'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 the 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 to be frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, located at 211 W. Fort Street, Suite 1310, Detroit, Michigan 48226, (313) 226-7450, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA), (866) 444-EBSA (3272).

You can read the materials listed above by making an appointment at the Fund Office during normal business hours. Also, copies of the materials will be mailed to you if you send a written request to the Fund Office. There will be a per-page charge for copying some of the materials. Before requesting materials, call the Fund Office and find out the cost. If a charge is made, your check must be attached to your request for the material.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND CONTACT THE FUND'S PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS.

We are required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that health information that identifies you is kept private to the extent required by law. We are also required to give you this notice regarding (1) the uses and disclosures of health information that may be made by the Plan of the Michigan Glass & Glazing Industry Welfare Insurance Fund, and (2) your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that Blue Cross/Blue Shield of Michigan has issued a separate Notice regarding disclosure of health information that is maintained on the Plan's behalf by those entities.

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose health information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. We may also share health information with a utilization review or precertification service provider. Likewise, we may share health information with another entity to assist with the coordination of benefit payments.

For Health Care Operations. We may use and disclose health information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities.

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To Inform You About Treatment Alternatives or Other Health Related Benefits. We may use your health information to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. For instance, we may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.

For Disclosure to the Fund's Trustees. We may disclose your health information to the Fund's Trustees for plan administration functions performed by the Fund's Trustees on behalf of the Fund including, but not limited to, reviewing appeals. We may provide summary health information to the Fund's Trustees so that the Fund's Trustees may solicit premium bids from health insurers or modify, amend or terminate the plan. We also may disclose to the Fund's Trustees information on whether you are participating in the Fund.

When Legally Required. We will disclose your health information when it is required to do so by any federal, state or local law.

For Public Health Activities. We may disclose your health information for public health activities such as the reporting of vital events such as birth or death or the tracking of products regulated by the Food and Drug Administration.

To Conduct Health Oversight Activities. We may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, we may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when we receive satisfactory assurance from the party seeking the information that reasonable efforts have been made to you of the request or, if such assurance is not forthcoming, if we have made a reasonable effort to notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. We may release health information to coroners or medical examiners for duties authorized by law or to funeral directors consistent with applicable law.

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or transplantation.

In the Event of a Serious Threat to Health or Safety. We may disclose your health information if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.

For Specified Government Functions. In certain circumstances, federal regulations may require us to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation. We may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

For Other Purposes. Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only if you provide a written authorization. If you provide us with written authorization

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to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission.

We may use or disclose your health information for other purposes not set forth in this Notice which we are permitted to do so without your written authorization or consent.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

The right to request restrictions or limitations on the health information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Fund's Privacy Officer. In your request, you must tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both; and (3) to whom the limits apply.

The right to request to receive confidential communication of your health information by an alternative means or at an alternative location if a disclosure of your health information could endanger you. The request must be made in writing to the Fund's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. We do not refuse to accommodate such a request unless the request imposes an unreasonable administrative burden. If the request is granted, the documentation of your request will be placed in your record.

The right to access documents regarding your eligibility, payment of claims, appeals or other similar documents for inspection and/or copying. Your request for access to documents with your health information must be in writing to the Fund's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the health information, copy it, or both, in the form or format requested at a time and place convenient to you and us. If you would like, you may receive a summary of the requested health information instead of your entire record, for a reasonable fee. You may also receive a copy of your health information by mail if you prefer. (We charge a reasonable, cost-based fee for copying, including labor and supplies [for instance, paper, computer disks] and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the health information or for processing the participant's request for access.) When a request for access is denied (in whole or in part), we will grant access to health information for which there are no grounds to deny access. We will also inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable), and how to file complaints with us and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, we will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official, and will notify you in writing of the reviewing official's determination.

The right to request to amend your health information if it is inaccurate or incomplete. You may request that your health information be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your health information should be amended. If you do not include a reason, we will not act on the request. When a request for amendment is accepted (in whole or in part), we will inform you that your request for amendment has been accepted. We will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and will inform them and other entities with whom the Fund does business who may rely on the disputed health information to your detriment. We will identify the record(s) that are the subject of the amendment request and will append the amendment to the record. When a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Fund, is accurate and complete, is not part of the record, or may not legally be changed such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that we provide the request for amendment and the denial in any future release of the disputed health information, and how to file a complaint with us or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, we may write a rebuttal

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statement and will provide a copy to the participant, and we will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed health information. If you do not choose to write a statement of disagreement with the denial decision, we are not required to include the request for amendment and denial decision letter with future disclosures of the disputed health information unless you request we to do so. Receipt of notification of amendment: When we receive notification from that your health information has been amended, we will ensure that the amendment is appended to your records, and will inform entities with whom it does business that may use or rely on your health information of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your health information. The right to an accounting extends to disclosures, other than disclosures made (1) for the purposes of treatment, payment or health care operations, including those made to business associates, (2) to individuals about their own health information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for national security or intelligence purposes; (8) to correctional institutions or law enforcement officials; and (9) those made prior to April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Fund's Privacy Officer. Your request must specify a time period, which may not be longer than six (6) years. You may request and receive an accounting of disclosures once during any twelve (12) month period for no charge. If you request more than one accounting within the same twelve (12) month period, a reasonable, cost-based fee may be charged. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The right to receive a paper copy of this Notice and any revisions to this Notice. You may request a copy of this Notice is writing to the Fund's Privacy Officer at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

LEGAL DUTIES OF THE MICHIGAN GLASS & GLAZING INDUSTRY WELFARE INSURANCE FUND REGARDING YOUR HEALTH INFORMATION

The Michigan Glass & Glazing Industry Welfare Insurance Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Michigan Glass & Glazing Industry Welfare Insurance Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Michigan Glass & Glazing Industry Welfare Insurance Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information we have about you as well as any information we receive in the future. If the Michigan Glass & Glazing Industry Welfare Insurance Fund changes its policies and procedures, the Michigan Glass & Glazing Industry Welfare Insurance Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Michigan Glass & Glazing Industry Welfare Insurance Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Michigan Glass & Glazing Industry Welfare Insurance Fund should be made in writing to the Fund's Privacy Officer. The Michigan Glass & Glazing Industry Welfare Insurance Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Fund's Privacy Officer, Michigan Glass & Glazing Industry Welfare Insurance Fund, 700 Tower Drive, Suite 300, P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957.

EFFECTIVE DATE

April 14, 2003

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

SOCIAL SECURITY NUMBER PRIVACY POLICY

The Michigan Glass & Glazing Industry Welfare Insurance Fund is required by Michigan law to make sure that your Social Security number and the Social Security numbers of your family members are kept private as set forth in that law.

The law permits the Fund to use Social Security numbers to verify your identity and the identities of your family members and to perform other functions related to providing health and welfare benefits under the Fund's Plan. Therefore, the Fund will continue to require Social Security numbers on application and enrollment forms. When your employer pays contributions on your behalf, the law permits your employer to provide the Fund with your Social Security number so that the Fund may determine your eligibility status. The law also permits the Fund to use Social Security numbers when authorized or required to do so by state or federal statute, by court order, or pursuant to legal discovery or process. The Fund will ensure to the extent practicable the confidentiality of those Social Security numbers.

In order to protect your privacy and in compliance with the law, the Fund's third-party administrator, BeneSys, Inc. ("BeneSys"), and Blue Cross/Blue Shield of Michigan ("BCBSM"), will use alternate identification numbers wherever feasible, including on benefits cards and explanations of benefits. BeneSys and BCBSM do not print Social Security numbers on the exterior of any envelope or package sent through the mail or in a manner that can be seen from the exterior of such envelope or package.

Only BeneSys' employees and agents and employees and agents other Fund service providers such as BCBSM may access the Social Security numbers of Fund participants and family members and only as necessary to provide services to the Fund. BeneSys uses practical means to limit access to written and electronic records in its possession that contain Social Security numbers to those employees and agents whose job duties require such access, such as securing areas where Social Security number information is located when not in use and requiring the use of passwords for access to electronic files containing Social Security numbers. BeneSys disposes of documents that contain Social Security numbers that the Fund is not actively using or is not otherwise obligated to retain by shredding and other processes that protect the confidentiality of the Social Security numbers. BeneSys' employees and agents must not disclose Social Security numbers by publicly displaying more than four sequential digits of a Social Security number or in any other manner prohibited by law.

The Fund notifies all service providers that they must ensure, to the extent practicable, the confidentiality of all Social Security numbers related to Fund participants and their families as required by law. The Fund may take action regarding service providers who fail to protect adequately the confidentiality of those Social Security numbers, including the termination of contracts.

SUBROGATION AGREEMENT

ASSIGNMENT OF ACKNOWLEDGMENT OF LIEN FOR THE BENEFIT OF THE MICHIGAN GLASS & GLAZING INDUSTRY WELFARE INSURANCE FUND

I, _____ (Name of Participant), hereby make this Acknowledgment of Lien for the Benefit of the Michigan Glass & Glazing Industry Welfare Insurance Fund (hereafter the "Assignment"), as stated below.

WHEREAS, I and/or my dependent(s) have made application to Michigan Glass & Glazing Industry Welfare Insurance Fund (hereinafter referred to as the "Fund") for benefits, which may include payment of hospital and other medical expenses and weekly disability benefits (hereinafter collectively referred to as the "benefits") arising from a medical condition commencing on _____; and

WHEREAS, the condition giving rise to the benefits may have been caused by a third party who maintains liability for payment of the expenses and benefits ("third party") and for all related medical and hospital expenses, as well as weekly compensation benefits, causing the Fund to maintain no liability to pay such benefits; and

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WHEREAS, a third party has refused to pay my and/or my dependent's(s') medical and hospital bills and has refused to pay weekly compensation benefits,

NOW, THEREFORE, in consideration for the advancement of the disability benefits/weekly wage replacement benefits which I have not received and/or medical and hospital expenses by the Fund which arise from my or my dependent's(s') medical condition and/or disability, I agree for myself and on behalf of my dependent(s) that I am indebted to the Fund and that I will reimburse or cause to be paid to the Fund all proceeds from any settlement, judgment or other recovery, whether a full or partial recovery, up to the amount of any expenses paid by the Fund, including payments made from an insurance carrier or money paid toward settlement of my or my dependent's(s') third-party claim, irrespective of any determination of who is at fault, and, further, that I will pay the Fund before I pay any other party out of those proceeds or recovery, whether full or partial. I acknowledge that any proceeds shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds those proceeds. I acknowledge that the Fund has first priority with respect to its rights set forth in this document. I agree for myself and on behalf of my dependent(s) to pursue any viable claim or a lawsuit against a third party and I hereby assign to the Fund (to the extent of the total amount of benefits which shall be paid to me or on my behalf or to my dependent(s) or on my dependent's(s') behalf) all right, title and interest in any money which I or my dependent(s) will receive or recover by trial, settlement, arbitration, redemption, voluntary payment or otherwise, and agree that I am and my dependent(s) is (are) subject to the assignment provisions. I understand that this Assignment is applicable to any person who succeeds to my or my dependent's(s') right of recovery, including my and/or my dependent's(s') estate, any person who serves as my or my dependent's(s') personal representative, guardian, next friend or heir and any other successor in interest to my or my dependent's(s') rights.

I hereby authorize and direct any insurance carrier, attorney and any other person now in possession of such proceeds or who comes into possession of such proceeds to pay the proceeds directly to the Fund.

I further understand and agree that the intent of this assignment is to assure the Michigan Glass & Glazing Industry Welfare Insurance Fund that I will reimburse to the Fund 100% of the amount paid to me or on my behalf arising from the medical condition giving rise to my claim against a third party, whether or not I or my dependent(s) recover in full or only partially. I understand and agree that the Fund does not have any financial responsibility with respect to the cost of legal services or other costs in connection with my or my dependent's(s') claims(s). I agree that the Fund shall maintain a lien on my or my dependent's(s') recovery from any third party, whether I/my dependent(s) recover money through civil lawsuit, arbitration, or other proceeding, pursuant to the Subrogation and Reimbursement section of the description of benefits provided by the Fund which has been distributed to me.

I will provide a copy of this Assignment to my or my dependent's(s') attorney if I/my dependent(s) have/has retained an attorney. If I/my dependent(s) have/has not yet retained an attorney or if I/my dependent(s) retain a new attorney to pursue claims arising from the medical condition described above, I agree to notify the Fund of the name and address of my/my dependent's(s') attorney within ten days of the retention of the attorney and provide a copy of the Assignment to any such attorney.

I agree that if I and/or my dependent(s) fail to pursue a claim against a third party, my employer or any other person who maintains liability to pay expenses on my or my dependent's(s') behalf and compensation to me/my dependent(s) within 90 days from the date of this Assignment and Acknowledgment of Lien, I on my own behalf and on behalf of my dependent(s) assign and subrogate to the Fund all of my/my dependent's(s') right, claims and interest any claim which I/my dependent(s) maintain and authorize the Fund, at its discretion, to sue, compromise or settle in my/my dependent's(s') name all such claims and to execute releases, endorse checks or drafts paid in settlement of such claim in my name and/or my dependent's(s') name(s), with the same force and effect as if I/my dependent(s) executed or endorsed them. I agree on my behalf and on behalf of my dependent(s) to cooperate fully with the Fund in the prosecution of such claims and testify at the Fund's request.

I also grant the Fund a security interest in any proceeds I/my dependent(s) receive as described above and agree to sign any additional documents requested by the Fund to perfect its security interest or to otherwise secure the Fund's subrogation rights to the proceeds.

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I HEREBY AGREE to notify the Fund at least thirty (30) days prior to the date, time and location of any settlement conference, trial or redemption hearing on any lawsuit\claim of mine or my dependent(s), at the following address:

Michigan Glass & Glazing Industry Welfare Insurance Fund
P.O. Box 966
Troy, MI 48099-0966
(248) 641-4957

I further understand and agree that if I do not reimburse the Fund or otherwise comply with my obligations under this Assignment as agreed, the Fund may take all appropriate steps to recover money it paid me or on my behalf or to my dependent(s) or on his/her/their behalf, including filing suit against me, deducting the balance owed by refusing to honor future claims of my family and me, or cutting off eligibility for benefits for my family and me.

Signature: _____

Date: _____

Social Security Number: _____

Address: _____

Telephone Number: (_____) _____

Signature: _____

Subscribed and sworn to before me
this ____ day of _____, 20____.

Notary Public, _____
County, State of _____

If you have retained an attorney, the following information must be provided and the enclosed Acknowledgment of Lien by Attorney must be completed and returned to our office for approval by the Board of Trustees before any claims will be considered in connection with this medical condition.

Attorney's Name: _____
Address: _____
Telephone Number: (_____) _____

ACKNOWLEDGMENT OF LIEN BY ATTORNEY

Dated: _____
Regarding Client: _____
(Please Print)

The undersigned attorney hereby acknowledges and recognizes a lien on behalf of the Michigan Glass & Glazing Industry Welfare Insurance Fund ("Fund") for all payments made by the Fund to or on behalf of the attorney's above-named Client(s) in connection with the Client's(s') injuries, including payments made for medical claims and wage loss.

The undersigned attorney hereby agrees to take steps to withhold sufficient money out of any proceeds of settlement, suit, or otherwise in connection with the Client's(s') claims when they are resolved, whether or not the Client(s) is/are made whole, to satisfy the lien, and after verification from the Fund as to the actual and then-current lien amount, agrees to take steps to effect disbursement of such money out of the Client's(s') proceeds through redemption, trial or otherwise, however they are designated and including proceeds allocated to medical expenses, lost wages, compensatory damages, attorneys fees, costs and interest, irrespective of any finding of liability of a third party.

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I acknowledge that any money recovered shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds such money.

ATTORNEY'S SIGNATURE

DATE: _____

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