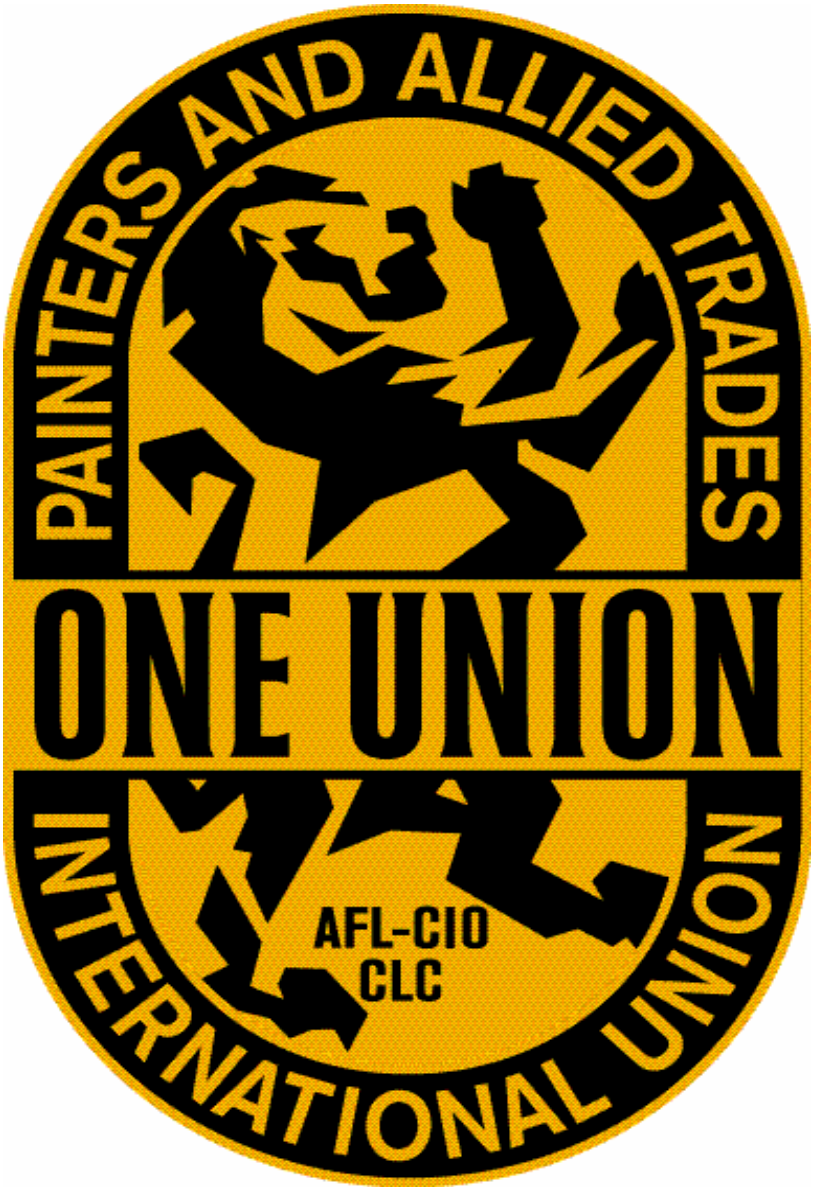
MICHIGAN STATE PAINTERS INSURANCE FUND



PLAN AND
SUMMARY PLAN DESCRIPTION
JANUARY 2022

Michigan State Painters Insurance Fund
Plan and Summary Plan Description

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SECTION I

ELIGIBILITY RULES

ACTIVE EMPLOYEES ELIGIBILITY

Employees Who May Become Eligible

Any Employee on whose behalf a Contributing Employer who is required to make contributions into the Michigan State Painters Insurance Fund by reason of a Collective Bargaining Agreement, or an Employee of a Local Union or District Council in accordance with a Participation Agreement, may become eligible if the Employee satisfies the Fund's eligibility requirements.

Nonbargaining unit employees of Contributing Employers may also establish and maintain eligibility for benefits from the Fund. Eligibility provisions set forth below do not apply to such nonbargaining unit employees of Contributing Employers, whose eligibility for benefits is governed by their Participation Agreements.

Initial Eligibility

Any Employee may become eligible for benefits under this Plan upon completion of 450 hours or more of employment for a Contributing Employer within a period of six (6) consecutive calendar months during which period of time contributions have been received from Contributing Employers by the Fund on the Employee's behalf.

Effective Date of Coverage

Coverage will become effective on the first day of the second month following the month for which the specified contributions are received.

EXAMPLE – The Employee completes 450 hours within a six (6) consecutive calendar month period as of June 1. Benefits will commence on the first day of the second month following the month for which the hours were worked or for which the contributions are received, which will provide eligibility for benefits effective August 1.

Hour Bank

After the 450 hours required to establish initial eligibility have been met, any hours that exceed the required 130 will go into an "hour bank" and can be utilized, as needed, to continue eligibility under the Plan. The hour bank allows for a maximum of three (3) months of eligibility (390 hours) to be banked.

Continuation of Coverage

Once having established initial eligibility as described above, an Employee's benefits will continue so long as the Employee has been credited with at least the required 130 hours of contributions by a Contributing Employer during the previous month.

In the event an Employee is not credited with the required number of hours for the month, and if the Employee has not accumulated an hour bank, the Employee may continue eligibility by contributing the difference between the hours reported and the required eligibility requirement.

EXAMPLE – An Employee required to earn the monthly hour requirement of 130 hours is reported for 100 hours; the Employee's hour bank is 0, so there is no hour bank to collect from. Therefore, to maintain eligibility, the Employee must self-pay for 30 hours (100 + 30 = 130) multiplied by the self-payment rate that the Trustees require.

Termination of Eligibility

An Employee's benefits will terminate on the first day of the third month following the month in which the Employee has failed to have the required credited hours contributed on his or her behalf or unless the Employee satisfies the Continuation of Coverage requirement or exercises the self-payment provision.

Self-Payment Provision

An Employee whose eligibility for benefits terminated by reason of lack of sufficient hours of work and who is not eligible though the Employee's hour bank may continue eligibility for benefits on a month-to-month basis, including Death Benefit, AD&D, Weekly Disability (subject to all provisions of that Section of the Plan), and maintain Continuity of Coverage in the Plan, thereby eliminating reinstatement requirements upon return to active employment. The following requirements must, however, be satisfied:

1. The Employee must have written certification from the Business Representative of his area that the Employee is not employed but is available to work for a Contributing Employer. Otherwise, the Employee must self-pay under the "COBRA Continuation of Coverage" provisions outlined below.
2. The Employee shall pay to the Fund the sum which the Trustees shall from time to time determine to be the appropriate monthly cost of such benefits. The Employee will be billed for the difference in the hours worked and the hours required to maintain eligibility. In the event no hours are reported, the Employee will be billed for the applicable monthly hour requirement and self-payment amount due.

3. Payment for each separate period of unemployment shall be made so as to reach the Fund Office by the due date indicated, and no more than thirty (30) days from receipt of notice of such ineligibility or notice of payment.
4. For each monthly payment made to the Fund under this provision, the Employee shall be credited with the number of hours of contributions that the Trustees shall from time to time determine to be appropriate.
5. No fully unemployed Employee may make contributions under this section for more than eighteen (18) months unless the Employee retires. In that case, the Employee may continue to self-pay according to the Retiree Schedule if qualified as a Retiree. A partially unemployed Employee may self-pay indefinitely.
6. Self-payments will be accepted only when there is continuity of coverage. An Employee who becomes ineligible during any month must make a self-payment for the first of the following month. If eligibility for benefits terminates due to failure to make self-payments, eligibility can only resume through working hours necessary to reinstate eligibility.

Reinstatement of Eligibility

If an Employee's eligibility is terminated, eligibility will be reinstated on the first day of the second month following completion of 450 hours of work within six (6) consecutive work months or fewer following the date of termination, for which contributions have been received from contributing employers by the Fund on the Employee's behalf. However, if an Employee whose eligibility is terminated has been eligible for benefits within the past twelve (12) months through either employer contributions, hour bank or self-payments not under COBRA, the Employee's eligibility will be reinstated on the first day of the second month following completion of 260 hours of work within three (3) consecutive work months following the date of termination, for which contributions have been received from contributing employers by the Fund on the Employee's behalf.

Eligibility During Disability

An Employee who is eligible for benefits under this Plan and who becomes disabled because of sickness or accident and who is unemployed because of such sickness or accident, including those covered under Workers' Compensation Laws, may continue to remain eligible for benefits during the period of such disability but not to exceed six (6) months from the date disability commenced, without deducting hours from the Employee's hour bank.

An Employee who continues to be disabled after six (6) months of continued eligibility, as provided above, will continue to be eligible so long as the Employee's hour bank, frozen on the date of disability, has at least 130 hours.

Once having exhausted his or her hour bank, which was frozen on the date the disability commenced, the disabled Employee may then elect to continue eligibility in force though self-payments to the Plan for a period of thirty-six (36) months under any one of the following options which the Employee may elect:

1. Self-pay, based on the required hours multiplied by the hourly contribution rate in force, as determined by the Bargaining Agreements.
2. Continue coverage in force pursuant to the COBRA provisions of the Plan.

Provisions Applicable to Service in the Armed Forces

If an Eligible Employee is absent from employment by reason of service in the uniformed services of the United States (hereinafter the "armed forces"), as defined in USERRA, the Employee's eligibility shall terminate on the date of induction, unless self-payment is made as described in this section. An Employee may elect to continue eligibility under the Plan for up to twenty-four (24) months after an absence due to service in the armed forces begins, or for the period of military service if shorter. The Employee must notify the Fund Office as soon as he or she volunteers or is called to active duty. An Employee who elects to continue eligibility under the Plan may be required to pay not more than 102% of the full premium under the Plan, except an Employee who performs service in the armed forces for fewer than thirty-one (31) days cannot be required to pay more than the self-payment amount set forth in the Plan. Eligibility under this section runs concurrently with eligibility through COBRA.

Upon discharge, an Employee whose eligibility terminated as a result of service in the armed forces will be reinstated to receive the unexpired portion of the eligibility benefit or hour bank eligibility to which the Employee was entitled at the time of termination. Exclusions and waiting periods will not be imposed in connection with reinstatement of eligibility on reemployment if an exclusionary waiting period would not have been imposed under the Plan had the Employee's eligibility not terminated as a result of absence for service in the armed forces, except for coverage of illness or injury that the Veterans Administration determines to be service related.

The reinstatement shall only become effective after the Employee notifies the Fund Office of the discharge and commences work for an Employer contributing to the Fund. The notice to the Fund Office may be given by the Employee's Union, the Employee, or the Employer.

If an Employee does not begin working for a Contributing Employer within ninety (90) days of the date of discharge from the armed forces, the Employee must complete the initial new Employee eligibility requirement if no Hour Bank exists.

Reciprocity

The Board of Trustees has entered into reciprocity agreements with other welfare benefit funds, providing for transfer of contributions paid to other funds and crediting of hours worked

in the areas of another funds. Reciprocity is not automatic and it is important that the Employee file an authorization card and notify the Fund Office immediately after starting work outside of the area covered by a Local Union participating in this Fund and contact the Local Union in the outside area to comply with any requirements in that area. If a reciprocity agreement is not in effect in an area where you are working, notify the Fund Office and the Trustees will explore the viability of entering into a reciprocity agreement with the Fund in the outside area.

Retirees – Continuation in the Plan

Disability, Early (age 55) and Normal (age 65) Retirees may elect to continue their eligibility through self-payments to the Fund as Retirees, provided they have maintained continuity of coverage in the Plan for at least ten months out of each year in the five years immediately preceding the Employee's retirement date and eligibility as an Active Employee is in place on the date of retirement. Employees who do not qualify to continue eligibility as Retirees may continue eligibility under COBRA Continuation Coverage described below.

However, an Employee who, upon retirement as an active Employee with eligibility as a Retiree under this section, continues eligibility as a nonbargaining unit employee under a Participation Agreement or who continues eligibility as a Retiree and then becomes eligible as a nonbargaining unit employee under a Participation Agreement, may continue eligibility as a Retiree after retirement as a nonbargaining unit employee, provided the Employee maintains continuity of eligibility without a loss of eligibility from the date of retirement as an Active Employee eligible under this section through the date of retirement as a nonbargaining unit employee working under a Participation Agreement.

Retirees and Retirees' spouses who are eligible for Medicare may pay for coverage under the Fund's Medicare Advantage program. A condition of such coverage under the Fund's Medicare Advantage program is enrollment in Medicare Parts A and B.

In the event a Retired Employee becomes eligible for benefits through work for an employer that does not contribute to the Fund, the new employer's plan will be primary and this Plan will be secondary. In other words, this Fund will only pay a Retiree's claim in the event there is no other coverage with any other benefit plan.

After the Employee initially retires, the Employee will not be eligible for the Sickness and Accident Weekly Disability Benefit or the Active Participant Death Benefit, except a Disability Retiree who has been approved for the Disability Waiver of Premium Benefit.

In addition to persons eligible to participate as Retirees described above, former officers of a Local Union who participate in the Fund as officers and who then become employees of the International Union of Painters and Allied Trades (IUPAT), and maintain continuous employment with the IUPAT from termination of employment with the Local Union, or District Council of which the Local Union is a component, through retirement from the IUPAT may

participate in the Fund as a Retiree through payment of the required monthly self-contribution, with resumption of eligibility coinciding with retirement from the IUPAT.

The Schedule of Benefits is the same as for the Active Employees except as follows:

1. All benefits will be coordinated with Medicare's approved allowance or any other Plan of Insurance.

2. The Death Benefit is reduced to three thousand dollars ($3,000).

3. No Weekly Disability Benefits will be paid.

4. No Accidental Death or Dismemberment Benefit will be paid.

5. No Pregnancy Benefit will be paid.

Disability Retirees must present proof of Total and Permanent Disability through the following:

1. Certification by Attending Physician, and

2. Social Security Certificate of Award.

The required monthly self-contribution by Retirees is subject to change as determined by the Board of Trustees.

Employee Becoming Entitled to Medicare

If the Employee becomes entitled to Medicare and if the Medicare entitlement will cause a covered spouse or dependent child to lose coverage under the Plan, then the Medicare entitlement is a COBRA qualifying event. All qualified beneficiaries (spouse and/or dependents) are entitled to self-pay for 36 months of continuation coverage.

Medicare Part D

Because the current prescription drug benefit offered to you through the Michigan State Painters Insurance Fund is as good as or better than that available under a Medicare prescription drug plan, the Trustees have decided to continue the current prescription drug coverage for retirees. It is therefore not necessary for you to enroll in the Medicare Part D Prescription Drug Program.

General Eligibility Provisions

Change of Eligibility Rules

The Trustees, in their discretion, are empowered to change or to amend these Eligibility Rules at any time.

A Note of Explanation

The Eligibility Rules represent the requirements which must be satisfied for you and your dependents to become and to remain eligible for benefits from this Plan. In the event the requirements are not satisfied, eligibility is lost and benefits are not payable. The Trustees reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the purpose of the Plan or who does not present a bona fide claim.

Remember: Changes in employment may have an effect on Employer contributions paid in your behalf. For example, Employer contributions cease in the event you:

1. Change job classifications from covered to non-covered employment, even if that employment is with the same employer; or
2. Change employment from a participating to a non-participating Employer.

You and your dependents may obtain, upon written request to the Fund Office, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan.

Effective Dates Of Coverage

Employee

Your effective date of coverage as an Employee will normally be the date you satisfy the requirements of the Eligibility Rules.

Dependents

Your effective date of coverage as a Dependent will be the date the Employee who sponsors you becomes eligible or the date you satisfy the definition of Dependent, whichever is later. Your coverage is not delayed if you or the Employee who sponsors you is disabled on that date.

This provision does not apply to a newborn child. The newborn child of an Eligible Employee becomes eligible on the date of birth.

Termination Dates of Coverage

Employee

Your coverage as an Employee under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

1. Failure to meet the requirements for continuing eligibility as shown in the Eligibility rules, including a failure to make any self-payments of contributions in a timely manner; or
2. Termination of the coverage classification under which you were continuing your eligibility; or
3. Termination of the Plan itself.

Dependents

Your coverage as a Dependent under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

1. Termination of eligibility for the Employee who sponsors you (for reasons other than the receipt of a Maximum Amount Payable); or
2. On the first day of the month next following the date you fail to meet the definition of Dependent; or
3. Failure to meet the requirements for continuing eligibility as shown in the Eligibility Rules, including failure to make any self-payments of contributions in a timely manner; or
4. Termination of the coverage classification under which you were continuing your eligibility; or
5. Termination of the Plan itself.

Health Insurance Portability and Accountability

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

Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C., 20210.

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

Family and Medical Leave

You may be eligible for up to 12 weeks of coverage under the Plan in a 12-month period for certain family and medical reasons under the Family and Medical Leave Act. You are eligible for coverage under the Act if:

1. You are unable to perform the functions of your job because of your serious health condition, the birth of your child or to care for your newborn child within one year of birth, the placement of a child with you for adoption or foster care or to care for your newly placed child within one year of placement, or to care for your child, spouse or parent who has a serious health condition;
2. You are employed by an employer with at least 50 Employees at your work site or with at least 50 Employees within a 75 mile radius of your work site; and
3. You have been employed by the employer at least 12 months;
4. You have worked at least 1,250 hours for the employer during the 12 months immediately before the requested leave; and
5. Your employer has adequate notice of the basis for the FMLA leave.

In addition to the conditions of eligibility under the Act described in Section 1 above, you may be eligible for up to 12 weeks of coverage under the Plan in a 12-month period if you are unable to perform the functions of your job for the following reasons:

1. You need to address a qualifying exigency arising from deployment to a foreign country of your spouse, child or parent who is a member of the armed forces; or
2. You are the spouse, child, parent or next-of-kin of an armed forces member and need to care for the member due to a serious health condition incurred or aggravated in the line of duty of active duty. You may take up to 26 weeks of leave under the Act for caregiving described in this section.

Your employer determines whether you are eligible for family or medical leave under the Act, not this Plan or its Trustees.

Both you and your employer are required to notify the Fund Office if you take a family or medical leave and to provide certain other information as required by the Trustees. Your coverage in the Plan will continue during the period of your family or medical leave, provided your employer pays contributions to the Plan at the same rate and in the same amount as if you were continuously employed during the period of your leave except for Employees eligible under the Eligibility During Disability provision of the Plan on whose behalf benefits are provided through pooled contributions, and you fully comply with all requirements established by the Trustees.

FMLA leave is coordinated with leave under the Eligibility During Disability provision of the Plan. An Employee will not receive duplicate credit for the same period of time. Therefore, credits granted to an Employee under the Eligibility During Disability provision of the Plan are concurrent with credits granted for FMLA leave, so that an Employee receiving benefits under the Eligibility During Disability provision of the Plan will not receive duplicate credit as a result of leave under the FMLA,

COBRA Continuation Coverage

This section discusses the rights and obligations of you and your eligible dependents under the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or "COBRA". You, your spouse and your dependents (if any) should take time to read this section carefully.

You will want to understand the following definitions of these important terms to understand your COBRA rights.

Continuation Coverage – the coverage available to you and your family under COBRA in the event you lose eligibility due to a Qualifying Event. If you elect Continuation Coverage, the Plan must provide coverage which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries for basic hospital, medical, and surgical benefits. Weekly Accident and Sickness Benefits and Accidental Death and Dismemberment Benefits are not provided.

Qualified Beneficiary – an individual who is covered under the Plan on the day before a Qualifying Event, as well as a newborn child or child placed for adoption with you during the period of Continuation Coverage. Qualified Beneficiaries are you, your spouse or your dependent child(ren).

Qualifying Event – an event that causes you and/or your family to lose coverage under the Plan. The specific events which are Qualifying Events for you, your spouse and/or your children are explained in detail in the following sections. Depending on the Qualifying Event, Continuation Coverage under COBRA is available for 18, 29 or 36 months.

Employee Right to Elect Continuation Coverage

You, as a Qualified Beneficiary, have the right to choose Continuation Coverage under COBRA if you lose eligibility for coverage under the Plan because not enough employer contributions are remitted to keep you eligible or your employment terminates for any reason except gross misconduct on your part. Either of those circumstances is what is known as a "Qualifying Event" for you, as an employee. These Qualifying Events entitle you and/or your family to elect 18 months of Continuation Coverage under COBRA.

The Trustees, through the Fund Office, determine when a Qualifying Event occurs as a result of a reduction of employer contributions or a termination of employment based on information contained on submitted employer contribution forms. The Fund Office will determine when the COBRA Qualifying Event has occurred within 120 days following receipt of the employer contribution form. The Fund Office will mail the COBRA election notice within 60 days after it has determined that you or a qualified beneficiary has lost eligibility for coverage. You have 60 days from the date you receive the election notice to elect to receive Continuation Coverage. If you do not elect coverage within 60 days, you no longer have a right to receive Continuation Coverage under COBRA.

If you qualify for Continuation Coverage under COBRA but do not elect such coverage for your entire family, your spouse and/or dependent children can still elect Continuation Coverage for themselves.

Continuation Coverage and Self-Payments Under COBRA

If you are an Active Employee and not disabled or retired and you choose to make self-payments to keep your eligibility because not enough employer contributions are made for you, you still have the right to elect continuation coverage. But, if you choose to make self-payments but stop making them for any reason, you can still elect Continuation Coverage under COBRA. But, the number of months for which you could have made self-payments is subtracted from the period for which you can get Continuation Coverage under COBRA. For example, if you would have lost eligibility because not enough employer contributions were made on your behalf and you made self-payments for four (4) months, the longest period for which you can elect Continuation Coverage under COBRA is fourteen (14) months.

Your Spouse's Right to Elect Continuation Coverage Under COBRA

Spouses of Employees or Retired Participants covered under the Plan, as Qualified Beneficiaries, have the right to choose Continuation Coverage under COBRA for themselves if the Spouses lose their group health care coverage under the Plan under any of the following circumstances:

- Termination of the Employee's employment (for reasons other than gross misconduct) or a reduction in the hours worked, which results in loss of eligibility under the Fund;
- Death of the Employee or Retired Participant;
- Divorce or legal separation from the Employee or Retired Participant; or
- The Employee or Retired Participant becomes entitled to Medicare and is not eligible to continue coverage for the Employee's spouse under another portion of the Plan or chooses not to continue such coverage.

These circumstances are known as Qualifying Events for your spouse. The first Qualifying Event entitles your spouse to elect 18 months of Continuation Coverage under COBRA. The other Qualifying Events would entitle your spouse to elect 36 months of Continuation Coverage under COBRA.

Your Dependent Children's Right to Elect Continuation Coverage Under COBRA

All of your dependent children covered under the Plan, as Qualified Beneficiaries, have the right to Continuation Coverage under COBRA if they lose their eligibility for coverage under the Plan under any of the following five circumstances:

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

These five circumstances are known as Qualifying Events for your dependent children. The first Qualifying Event entitles your dependent child(ren) to elect 18 months of Continuation Coverage under COBRA. The other Qualifying Events entitle your dependent children to elect 36 months of Continuation Coverage.

A newborn or adopted child will automatically be extended Continuation Coverage under COBRA if the parents already have COBRA coverage. This may involve an increase in the COBRA premium charged. A newborn child or an adopted child (or the child's custodian or guardian) has a right, separate from his or her parents, to elect Continuation Coverage under COBRA for 18 or 36 months, depending on the Qualifying Event, even if the child's parent(s) do not elect Continuation Coverage under COBRA.

Continuation Coverage for Disabled Persons

If you, your spouse, or any dependent child, as Qualified Beneficiaries, qualify for Social Security disability benefits at the time of a Qualifying Event then that Qualified Beneficiary can elect 18 months of Continuation Coverage under COBRA. Or, at any time during the first 60 days after you lose coverage due to a Qualifying Event you may purchase up to an additional 11 months of Continuation Coverage (or a total of up to 29 months).

The disabled person and other family members who are not disabled may purchase this additional Continuation Coverage under COBRA (subject to the applicable premium).

The Qualified Beneficiary must be determined eligible for Social Security disability benefits before the end of the 18-month Continuation Coverage period and must notify the Fund Office during the 18-month period and within 60 days after the Social Security Administration awards Social Security benefits to the disabled person to obtain this additional coverage.

The Fund charges eligible disabled persons and their families a higher premium (up to 150% of the regular COBRA premium) for the up to additional 11 months of Continuation Coverage under COBRA. The higher premium applies to the disabled person and for other family members who elect to purchase additional Continuation Coverage under COBRA.

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

Second Qualifying Events

The following rules concern second Qualifying Events under COBRA. These rules only apply if the original Qualifying Event was termination of the employee's employment (for reasons other than gross misconduct) or reduction in the number of hours worked by the employee. If you or your other Qualified Beneficiaries elect Continuation Coverage under COBRA because of that Qualifying Event and a second Qualifying Event occurs during the coverage available as a result of the first Qualifying Event [or, 29 months if the 11 month extension due to disability applies], then you (or they) may purchase additional Continuation Coverage, but total Continuation Coverage can never exceed 36 months. An example of a second Qualifying Event would be:

- Death of the employee, if he or she is a covered employee under the Plan;
- Divorce or legal separation of the employee and his/her spouse;
- The employee, if a covered employee under the Plan, becomes enrolled in Medicare (Part A, Part B, or both); or

- For dependent children, the dependent child ceases to satisfy the Plan's definition of a "dependent child" (The rules for second qualifying events also apply to newborn or adopted children.)

The 36 total months of Continuation Coverage available under COBRA when a second Qualifying Event occurs includes the number of months you have already been covered under Continuation Coverage because the first Qualifying Event and months for which you made self-payments to stay eligible after the first Qualifying Event. The 36 month total is not in addition to any months of Continuation Coverage and self-payment coverage that you have already had because of the first Qualifying Event. The Plan Administrator (Fund Office) must be notified within 60 days of the second Qualifying Event or the additional extended coverage will not be allowed.

Proof of Insurability is Not Needed to Elect Continuation Coverage

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

Procedure for Obtaining Continuation Coverage Under COBRA

Once the Fund Office knows that a Qualifying Event has occurred which qualifies you or other family members who are Qualifying Beneficiaries for Continuation Coverage under COBRA, the Fund Office will attempt to notify you or your family member of their rights to elect Continuation Coverage.

You will have 60 days after the date on the election notice within which to notify the Fund Office whether or not you want the Continuation Coverage under COBRA. If you do not elect the coverage within the 60-day time period, your right to continue your group health care coverage will end.

Termination of Continuation Coverage Under COBRA

The law provides that Continuation Coverage under COBRA may be canceled by the Fund for any of the following reasons:

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

4. The person remitting Continuation Coverage payments becomes entitled to Medicare.

Although your Continuation Coverage under COBRA may be canceled as soon as you are covered by Medicare, a spouse or dependent child receiving Continuation Coverage at that time may continue purchasing such coverage for up to 18 or 36 months minus any months of Continuation Coverage received immediately before your coverage under Medicare. This option applies only if a spouse or dependent child is not also covered by Medicare.

Disabled Persons

If you, as a covered Employee, your spouse, or any dependent child qualifies for Social Security disability benefit within sixty (60) days after you lose coverage for the reasons listed above, you may purchase up to an additional eleven (11) months of Continuation Coverage under COBRA (or a total of 29 months).

This additional Continuation Coverage under COBRA may be purchased not only for the disabled person, but also for other family participants who are not disabled (subject to the applicable premium).

To obtain this additional Continuation Coverage under COBRA, the disabled person (Employee, spouse, or dependent child) must be determined eligible for Social Security benefits before the end of the eighteen (18) month continuation coverage period and must notify the Fund Office during the eighteen (18) month period and within sixty (60) days after the Social Security Administration awards Social Security benefits to the disabled person.

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

Eligibility for extended COBRA coverage because of disability ends when the disabled person is deemed to no longer be disabled. Federal law requires a disabled person to notify the Fund within thirty (30) days after a final Social Security Administration determination that the person is no longer disabled.

Spouse

If you are the Dependent spouse of an eligible Employee, you can choose Continuation Coverage under COBRA for up to thirty-six (36) months if you lose eligibility due to:

1. The death of your spouse; or
2. The termination of your spouse's covered employment or a reduction in your spouse's hours of covered employment; or

3. A divorce or legal separation from your spouse; or
4. Termination of your eligibility because your spouse becomes eligible for Medicare.

Dependent Children

If you are the Dependent child of an eligible Employee, you can choose Continuation Coverage under COBRA for up to thirty-six (36) months if you lose eligibility due to:

1. The death of a parent; or
2. The termination of your parent's covered employment or a reduction in their hours of covered employment; or
3. A parent's divorce or legal separation; or
4. Termination of your eligibility because a parent becomes eligible for Medicare; or
5. Your failure to meet the definition of "Dependent child" contained in the Plan.

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

Eleven (11) Month Extension of Continuation Coverage Under COBRA for Disabled Qualified Beneficiaries

If the eligible Participant is disabled (as determined by the Social Security Administration) at the time of a Qualifying Event involving termination of employment or a reduction in hours, the eighteen (18) month continuation period may be extended eleven (11) months, up to a maximum of twenty-nine (29) months for the disabled individual. The eligible Participant is responsible for electing the additional eleven (11) months of continuation coverage and notifying the Fund Office within the time frames described herein.

Your Obligations

Under COBRA, a covered Employee or a family participant has a responsibility to notify the Fund Office about a divorce, legal separation, or a child losing dependent status under the Plan rules. Such notification should take place immediately after any qualifying event. If such an event is not reported to the Fund Office within sixty (60) days after a qualifying even occurs, Continuation Coverage under COBRA will not be offered.

The surviving spouse (or dependent child) of a deceased Employee should contact the Fund Office immediately after the Employee's death. Such action will help assure that Continuation Coverage is offered to the surviving spouse and children at the earliest possible date.

The law requires the COBRA election notice to be sent to the last known address on file at the Fund Office. If the election notice is sent to the wrong address due to your failure to notify the Fund Office about a change in address, the sixty (60) day time limit will not be extended and you may lose the opportunity to elect Continuation Coverage under COBRA.

You are also required to notify the Fund Office if you or any family participants are covered under another group health care plan at the time you receive a COBRA election notice (for example, if you are covered as a dependent under your spouse's plan), or if you elect Continuation Coverage under COBRA, at any time you or a family participant later becomes covered under another group health care plan, including Medicare.

The Fund Office may require you to provide information about your coverage under another group health care plan to determine whether you are entitled to elect Continuation Coverage under COBRA. Under certain conditions, COBRA does not have to be provided if you are covered under another group health care plan. The Fund may seek reimbursement directly from you if medical expenses are paid by the Fund because you or your dependents do not notify the Fund of other health care coverage.

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

In addition to Continuation Coverage under COBRA, you will also have the option to purchase alternative coverage which provides health care coverage equal to the COBRA coverage plus other benefits for a premium which may be less than the COBRA premium. Details will appear on your COBRA Election Notice.

Application for COBRA Benefit

The Fund Office will provide you with specific instructions, rates and benefit descriptions once your notice is received and if you qualify for Continuation Coverage under COBRA. Your eligibility for Continuation Coverage under COBRA depends on you making the required payments in a timely manner. If you fail to make a timely payment of any required payment, Continuation Coverage under COBRA will terminate and cannot be reinstated.

Limitations

In addition to the limits stated above, your rights to COBRA continuation terminate when the earliest of the following events occurs;

1. The date on which you become entitled to Medicare;
2. The date on which you become entitled to coverage under another group health program (except for coverage of a "pre-existing condition" which is excluded by the Fund);
3. The date you fail to make the self-contribution in the amount and by the time required.

If more than one qualifying event occurs (such as a divorce which happens during a layoff), the maximum continuation period is thirty-six (36) months from the date of the first qualifying event.

Only persons eligible in the Plan on the date of the original qualifying event are eligible for COBRA continuation coverage. Newly married spouses and any children (legally adopted or stepchildren) who were not eligible in the Plan on the date of the qualifying event cannot be added to COBRA continuation coverage.

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

Qualified Medical Child Support Orders

Under certain circumstances as required under Federal Law, the Plan will provide coverage for your children when you and your spouse divorce, even if you do not have custody of the children. These requirements are summarized below.

The process begins when the Plan receives a qualified medical child support order (QMCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

1. Issues from a court under a state's domestic relations law.
2. Requires you to provide group health coverage available under the Plan for your child.
3. Clearly specifies:
    a. The name and the last known mailing address of the Participant and each child covered by the order.

b. A reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which such type of coverage is to be determined.

c. The period to which the order applies and that coverage may terminate under the same terms and conditions generally applicable to other Plan beneficiaries.

d. That the order applies to the Plan.

4. Is determined to be a QMCSO by the Board of Trustees.

On receipt of a court order providing for coverage of a child, the Fund Office will provide written notification to you and each identified child or representative that it has received the order.

If the Order meets the above requirements, the Plan will provide written notification to you and each child, or his or her representative, of the child's eligibility for coverage. This notice will include a description of the procedures to be followed, and a form for designating the parent or other person as the child's representative for Plan purposes. More detailed information on this subject is contained in the Plan's Procedures to Determine Qualified Status of Medical Child Support Orders, which you can obtain without charge upon request from the Fund Office.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

1. Get a copy of your health and claims records
2. Correct your health and claims records
3. Request confidential communication
4. Ask the Fund to limit the information the Fund shares
5. Get a list of those with whom the Fund shared your information
6. Get a copy of this privacy notice
7. Choose someone to act for you
8. File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that the Fund uses and shares information as it:

1. Answers coverage questions from your family and friends
2. Provides disaster relief
3. Markets its services and sells your information

Uses and Disclosures

The Fund may use and share your information as it:

1. Helps manage the health care treatment you receive
2. Runs its organization
3. Pays for your health services
4. Administers your health plan
5. Helps with public health and safety issues
6. Does research
7. Complies with the law
8. Responds to organ and tissue donation requests and works with a medical examiner or funeral director
9. Address workers' compensation, law enforcement, and other government requests
10. Responds to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

1. You can ask to see or get a copy of your health and claims records and other health information the Fund has about you. Ask how to do this.
2. The Fund will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Fund may charge a reasonable, cost-based fee.

Ask the Fund to correct health and claims records

1. You can ask the Fund to correct your health and claims records if you think they are incorrect or incomplete. Ask how to do this.
2. The Fund may say “no” to your request, but it will tell you why in writing within 60 days.

Request confidential communications

1. You can ask the Fund to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
2. The Fund will consider all reasonable requests, and must say “yes” if you tell the Fund you would be in danger if it does not.

Ask the Fund to limit what the Fund uses or shares

1. You can ask the Fund not to use or share certain health information for treatment, payment, or its operations.
2. The Fund is not required to agree to your request, and the Fund may say “no” if it would affect your care.

Get a list of those with whom the Fund has shared information

1. You can ask for a list (accounting) of the times the Fund has shared your health information for six years prior to the date you ask, who the Fund shared it with, and why.
2. The Fund will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Fund to make). The Fund will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you

1. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
2. The Fund will make sure the person has this authority and can act for you before it takes any action.

File a complaint if you feel your rights are violated

1. You can complain if you feel the Fund has violated your rights by contacting the Fund using the contact information in this Plan.
2. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
3. The Fund will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell the Fund your choices about what the Fund shares. If you have a clear preference for how the Fund shares your information in the situations described below, talk to the Fund. Tell the Fund what you want the Fund to do, and the Fund will seek to follow your instructions.

In these cases, you have both the right and choice to tell the Fund to:

1. Share information with your family, close friends, or others involved in payment for your care
2. Share information in a disaster relief situation

If you are not able to tell the Fund your preference, for example if you are unconscious, the Fund may go ahead and share your information if it believes it is in your best interest. The Fund may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Fund never shares your information unless you give written permission:

1. Marketing purposes
2. Sale of your information

The Fund's Uses and Disclosures

How does the Fund typically use or share your health information?

The Fund typically uses or shares your health information in the following ways:

Help manage the health care treatment you receive

The Fund can use your health information and share it with professionals who are treating you.

Example: A doctor sends the Fund information about your diagnosis and treatment plan so the Fund can arrange additional services.

Run the Fund's organization

1. The Fund can use and disclose your information to run its organization and contact you when necessary.
2. The Fund is not allowed to use genetic information to decide whether it will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: The Fund uses health information about you to develop better services for you.

Pay for your health services

The Fund can use and disclose your health information as it pays for your health services.

Example: The Fund shares information about you with your dental plan to coordinate payment for your dental work.

How Else Can the Fund Use or Share Your Health Information?

The Fund is allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. The Fund has to meet many conditions in the law before it can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

The Fund can share health information about you for certain situations such as:

1. Preventing disease
2. Helping with product recalls
3. Reporting adverse reactions to medications
4. Reporting suspected abuse, neglect, or domestic violence
5. Preventing or reducing a serious threat to anyone's health or safety

Do research

The Fund can use or share your information for health research.

Comply with the law

The Fund will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Fund is complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

1. The Fund can share health information about you with organ procurement organizations.
2. The Fund can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

The Fund can use or share health information about you:

1. For workers' compensation claims
2. For law enforcement purposes or with a law enforcement official
3. With health oversight agencies for activities authorized by law
4. For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

The Fund can share health information about you in response to a court or administrative order, or in response to a subpoena.

The Fund's Responsibilities

1. The Fund is required by law to maintain the privacy and security of your protected health information.
2. The Fund will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. The Fund must follow the duties and privacy practices described in this notice.

4. The Fund will not use or share your information other than as described here unless you tell the Fund it can do so in writing. If you tell the Fund it can, you may change your mind at any time. Let the Fund know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

The Fund can change the terms of this notice, and the changes will apply to all information the Fund have about you. The new notice will be available upon request, and the Fund will mail a copy to you.

More Stringent State and Federal Laws

The Fund will follow laws of the State of Michigan if applicable, and other federal laws when they require greater limits on disclosures than HIPAA.

For More Information Contact the Privacy Officer

For questions about this Notice, to exercise your privacy rights, or to file a complaint, you may contact the Fund's Privacy Officer, Marlene McDiarmid, Medical Claims Department Manager, Michigan State Painters Insurance Fund, 6525 Centurion Drive, Lansing, Michigan 48917, (517) 321-7502.

GENERAL DEFINITIONS

Covered Person

A Covered Person means a person eligible for benefits under the Plan and is synonymous with Eligible Person.

Educational Institution

Educational institution means a trade school, college or university or other organization whose primary purpose is training and which regularly charges tuition for such education or training.

Educational institution does not include work-study or other training programs during which the trainee receives compensation.

Eligibility Rules

The Eligibility Rules mean rules that determine eligibility for benefits under the Plan for Active Employees and their Dependents, Totally and Permanently Disabled Employees and their Dependents, Self-Pay Employees and their Dependents, Retirees and their Dependents and all other persons eligible for benefits.

Eligible Dependents

Dependents shall become eligible when the Employee becomes eligible. Dependents cannot attain initial eligibility independent of an Employee's initial eligibility.

Eligible Dependents are the following:

1. The legal spouse of the eligible Employee.
2. The eligible Employee's natural child, foster child, legally adopted child, prospective adopted child placed with the Employee during the legally required trial period before approval of the adoption by a court, a child for whom the Employee has been appointed full legal guardian with physical custody through a court order, or stepchild, except a stepchild whose expenses covered by the Plan are required to be paid in part or full by a parent or other person not the Employee under court order or otherwise, whether or not actually paid by such person, who is younger than twenty-six (26) years old.

In order to qualify for eligibility as an Eligible Dependent, the following conditions must be met:

a. A child must not be eligible to enroll in an employment-based health plan maintained by the child's employer or the child's spouse's employer; and

b. For a child between 19 and 26 years old (an "adult child"), enrollment with the Fund in the form and in accordance with deadlines determined by the Board of Trustees of the Fund for coverage in a Plan year. Failure to enroll an adult child in the Fund as specified will preclude coverage of the child until the following Plan year. A limited exception applies for an adult child who is covered under an eligible employment-based health plan of his or her employer or spouse's employer at the end of an enrollment period and loses that coverage, in which case you will have 30 days from the loss of such other coverage to enroll the child in the Fund. As an express condition of the Fund's coverage, you must also

certify at times determined by the Fund that each of your adult children covered by the Fund is not eligible to enroll in an employment-based health plan through his or her employer or spouse's employer.

c. Information is presented, upon request, supporting the Dependent's status.

It is understood that coverage of a dependent child may also be established in those cases where the Fund has received a "Qualified Medical Child Support Order" (QMCSO) entered by an appropriate court as defined under applicable federal law and accepted as such by the Fund. Normally, such an order will be issued in a divorce or other family law action, which recognizes the child's right to health benefits under the Plan.

3. Any natural child of the eligible Employee who is at least twenty-six (26) years of age and is totally and permanently disabled because of a qualifying physical handicap or mental condition. To be considered a qualified physical handicap or mental condition under this definition, it must:

   1) occur before the child reaches age twenty-six (26); and

   2) be certified by a Physician; and

   3) render the child incapable of self-sustaining employment so as to make the child dependent upon the parents for financial support and maintenance.

   Initial proof of such disability and financial dependency must be furnished to the Trustees within 60 days of the child reaching twenty-six (26) years of age. Subsequent proofs may be required by the Trustees at their discretion.

Dependent coverage terminates on the date:

1. An eligible child is covered under an employment-based health care plan of the child's employer or child's spouse's employer.

2. A spouse is covered under an employment-based health plan of the spouse's employer.

3. The qualifying disability ceases;

4. The QMCSO terminates;

5. The Employee's coverage is terminated; or

6. The person covered as a Dependent does not meet the criteria as a Dependent under the Plan.

If one spouse is covered under the Plan pursuant to the terms of a Collective Bargaining Agreement and one spouse is covered under the terms of a Participation Agreement:

1. Their children may be covered as Dependents of the husband or the wife, but not both; and
2. Neither may be covered as the Dependent of the other at the same time.

The term Eligible Dependent does not include a child or spouse of a dependent child.

Eligible Employee

An Eligible Employee means any person who: (1) is working within the jurisdiction of and is covered under the terms of the Collective Bargaining Agreement or is covered under a Participation Agreement entered into between the Fund and the Employer, and (2) is eligible for benefits as set forth in the Michigan State Painters Insurance Fund Eligibility Rules.

Eligible Person

An Eligible Person means a person eligible for benefits under the Plan and is synonymous with Covered Person.

Employee

An Employee means a person actively employed by an Employer, on whose behalf Employer contributions are required to be made.

Employer

Employer or Contributing Employer means any association or individual employer who has duly executed a written agreement with the Union and is thereby required to make contributions to this Fund on behalf of its Employees, and any employer who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement is also included in this definition.

Health Insurance Portability and Accountability Act

Law which limits the circumstances under which coverage may be excluded for medical conditions before your enrollment.

Totally Disabled and Total Disability

Totally Disabled and Total Disability, unless otherwise specifically defined, refer to disability resulting solely from a sickness or accidental bodily injury which prevents an Employee from engaging in any occupation or employment for compensation or profit or prevents a Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health for which the person is eligible for Social Security Disability Benefits. A copy of the Social Security Administration Award Letter is required for proof of total disability.

Trust Agreement

Trust Agreement means the Agreement and Declaration of Trust establishing the Michigan State Painters Insurance Fund and that instrument as it may be amended from time to time.

Trustees

Trustees mean the Employer Trustees and the Union Trustees, collectively, as selected under the Trust Agreement, and as constituted from time to time in accordance with the provisions of the Trust Agreement.

Trust Fund

Trust Fund or Fund means the Michigan State Painters Insurance Fund.

Union

Union means a Union which has executed a written agreement with an Employer who, in accordance with such agreement, participates in and contributes to the Michigan State Painters Insurance Fund.

SECTION II

BLUE CROSS BLUE SHIELD

OF MICHIGAN

COMMUNITY BLUE

PLAN 4

Michigan State Painters Insurance Fund

This section of the Summary Plan Description is written by Blue Cross Blue Shield of Michigan Representatives and explains only BCBSM benefits.

Blue Cross Blue Shield of Michigan

600 Lafayette East
Detroit, Michigan 48226-2998

Dear Subscriber,

Thank you for choosing Blue Cross Blue Shield of Michigan as your provider of health care coverage. We are committed to providing you with excellent value and quality service. We want you to be aware of your benefits and to understand how your health care coverage works. With this in mind, we have designed this booklet as an easy-to-read guide to your program. We encourage you to take time to review and become familiar with this booklet and to use it as a reference guide in the future. And remember, if you have specific questions about your coverage; contact the Blue Cross Blue Shield of Michigan Customer Service Office near you.

Sincerely,

Blue Cross Blue Shield Employees

About Your Benefits Guide

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

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

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

To obtain a copy of your certificates and riders, please contact your plan administrator. This guide replaces any prior descriptions of benefit information you may have received. Please discard any prior descriptions of your benefits.

How to Reach Us

Customer Service Information

When you call or write to our Customer Service Center, please refer to your contract number on your Blue Cross Blue Shield ID Card.

When Calling

Our customer service hours are Monday through Friday from 8:30 a.m. to 5 p.m.
Here's how you can reach us:

State-wide: 877-790-2583

BlueCard Program (800) 810-BLUE (2583)

Hearing and Speech Impaired Customers

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

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

When Writing

Please send all correspondence to:

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

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

Special Servicing Numbers

Anti-Fraud Hotline (800) 482-3787

Hearing-Impaired Customers (800) 240-3050

Human Organ Transplant Program (800) 242-3504

Individual Case Management Program (800) 845-5982

Senior Help Line (800) 327-9148

Second Surgical Opinion Program

Detroit Area (313) 225-5982

All other Michigan area codes (800) 832-6789

Web site Addresses

Blue Cross Blue Shield of Michigan Home Page - www.bcbsm.com

Anti-Fraud - www.bcbsm.com/anreport.shtml

BCBSM Customer Service Offices

Blue Cross Blue Shield of Michigan has many conveniently located Customer Service Offices to assist you with any questions you may have about your coverage. You may visit these locations for assistance.

Detroit – Bricktown Customer Service Center

500 E Lafayette Blvd, Detroit, MI

9 a.m. to 5 p.m., Monday through Friday. Medicare representatives are available on Monday, Wednesday and Friday.

Blue Care Network-The Commons

20500 Civic Center Drive, Southfield, MI

Service center and corporate headquarters. Hours: 9 a.m. to 5 p.m., Monday through Friday

Shelby Twp-Oakland/Macomb

6100 Auburn Rd, Shelby Twp, MI

9 a.m. to 5 p.m., Monday through Friday

Ann Arbor – Blue Care Network – Green Road Facility

2311 Green Rd, Ann Arbor, MI

Service center. Hours: 9 a.m. to 5 p.m., Monday through Friday

Flint-Linden Creek Service Center

4520 Linden Creek Parkway, Flint, MI

Hours: 9 a.m. to 5 p.m., Monday through Friday, closed for lunch between 12:30 and 1:45 p.m.

Lansing-South Capitol Avenue Building

232 S. Capitol Ave, Lansing, MI

9 a.m. to 5 p.m., Monday through Friday

Portage Customer Service

8175 Creekside Drive, Portage, MI

9 a.m. to 5 p.m., Monday through Friday

Grand Rapids-Stekette's Building

86 Monroe Center NW, Grand Rapids, MI

9 a.m. to 5 p.m., Monday through Friday, closed for lunch between 12:30 and 1:45 p.m.

Holland Service Center

151 Central Ave, Holland, MI

9 a.m. to 5 p.m., Monday through Friday, closed for lunch between 12:340 and 1:45 p.m.

Traverse City Service Center

202 E. State St., Traverse City, MI

9 a.m. to 5 p.m., Monday through Friday

Marquette Service Center

415 S. McClellan Ave, Marquette, MI

9 a.m. to 5 p.m., Monday through Friday

General Information

Your Identification Card

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

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

Line 1: Contract Number is a Unique Identification Number which replaces the use of your Social Security Number to protect your identity.

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

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

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

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

Here are some tips about your ID card:

- Sign the signature strip immediately to help prevent fraudulent use.
- Carry your card with you at all times to help avoid delays when you need medical attention.
- If you, or anyone in your family, needs a card, please call your local Customer Service office for assistance.
- Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.
- Call us if your card is lost or stolen. You can still receive services by giving the provider your contract number to verify your coverage.

Customer Service

As a Blues member you are very important to us. You should call your local Customer Service anytime you have a question about your health care plan. For your convenience, we've listed our customer service phone number in Section 1.

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

- Have your contract number ready
- If you are questioning a service, please provide:
- Patient and provider's name
- Date the patient was treated
- Type of service, such as an office visit
- Charge for each service
- When corresponding with us, please make sure your contract number is on each page
- and you should keep a copy for your records.
- When visiting our Customer Service offices, please bring a copy of any bills, forms or other materials related to your inquiry.

Preventing Fraud

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

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 our Anti-Fraud Hotline:

- In Michigan: 1-800-482-3787
- Outside Michigan, call Detroit Main Office Customer service at: 1-313-225-8100. Your call will be transferred to our Anti-Fraud Unit.

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

Or you may write:

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

Eligibility

Dependent Coverage

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

Eligible dependents are:

- Your spouse
- Children until they reach age 26. They may remain covered to any age if they are "totally and permanently disabled by either a physical or mental condition prior to age 26."

Eligible children include:

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

(Please refer to the definition entitled "Eligible Dependents" located in the General Definitions section for more detailed Plan requirements.)

Dependent Continuation Coverage

Dependents who are between 19 and 26 may continue coverage under your contract.

Important: Coverage of a dependent child between 19 and 26 years old (an "adult child"), is expressly conditioned on enrollment of the adult child with the Fund in the form and in accordance with deadlines determined by the Board of Trustees of the Fund for coverage in a Plan year. Failure to enroll an adult child in the Fund as specified will preclude coverage of the child until the following Plan year. As an express condition of the Fund's coverage, you must also certify annually that each of your adult children covered by the Fund is not eligible for employer-sponsored health plan coverage through his or her employer or spouse's employer.

If you have a dependent who is no longer eligible for health coverage on your contract, we have many benefit options available to continue his or her coverage. Contact a customer service representative for more information.

To Add a Dependent to Your Contract

When you become a BCBSM subscriber, your eligible dependent family members may be added to your contract. To add a dependent to your contract, notify the Fund Office and fill out an **Enrollment/Change of Status Form.** Please notify the Fund Office within 30 days* of the date any change occurs *(date of event)*, so we can adjust our records.

When Dependent Coverage Will Be Effective

Your Spouse on the date of marriage. Your Newborn on the date of birth. Your Adopted Child on the date of placement. Placement occurs when the member becomes legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required. Child Under Legal Guardianship on the date legal guardianship is granted or the date of petition for legal guardianship is filed and residency is established. You must notify us within 30 days of the date your child turns 19.

** If we are notified more than 30 days after the date of the event, the change to our contract could be delayed until your group's next reopening date.*

To Remove a Dependent From Your Contract

When you (the member) need to remove a dependent from your contract, notify the Fund Office and fill out an Enrollment/Change of Status Form.* Be sure to include your group and contract numbers, the dependent's Social Security number, the date you would like to dependent removed, and the reason for removing the dependent. See the chart below for information about removing dependents.

Remember, if a dependent child is no longer eligible, you must notify the Fund Office promptly.

A Dependent Will Be Removed As Follows:

- Your Spouse on date of the divorce or legal separation.
- Your child on reaching age 26.
- Any Dependent on the first day following the date of death.

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

To Change Your Address

If you change your address, or if your address is incorrect in our records, please notify the Fund Office and fill out an **Enrollment/Change of Status Form** promptly. This will ensure that you will continue to receive any notices BCBSM sends to you. Remember to include your group and contract numbers whenever you contact us.

Continuing Coverage on Your Own

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

1. Continue temporary coverage through the Fund under the self-payment program; or
2. Continue **temporary** coverage through the Fund under a federal legislative act known as **COBRA** (Consolidated Omnibus Budget Reconciliation Act), **or**
3. Convert to individual coverage, called **Group Conversion** through Blue Cross Blue Shield of Michigan. We've provided an explanation for both options; however, you will need to contact the Fund Office to clarify eligibility dates and to select the type of coverage best for you.

Choosing A Network Provider

What You Need to Know

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

- What is a network provider
- What is a non-network provider
- BlueCard PPO program
- Care out of the country

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

Network Providers

Community Blue PPO uses a network of physicians, hospitals, and other health care specialists who have signed agreements with us to accept our approved amount as payment in full for covered services. When you use PPO network providers, your out-of-pocket costs for covered services are limited to the **deductible and co-payments** listed.

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

- Choose a provider from our Community Blue/Blue Preferred PPO Provider Directory, or website www.bcbsm.com
- Make your appointment directly with that provider. With Community Blue PPO, you do not have to choose just one provider for your care and you do not have

to notify us if you decide to change physicians. Just remember to select your provider from the directory and you will stay in-network. If you would like to verify if a provider is in our network, please call the Customer Service number.

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

- Services where there is no network available
- Services covered under a separate Prescription Drug, Dental, Vision, or Hearing plan

Special Note for Parents of Students: If you have dependents attending school in Michigan, but living away from home, you should help them choose a Community Blue Preferred PPO physician near their school. If you need a statewide provider directory, please call the Customer Service number.

Change in Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with our PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact our Customer Service office for assistance. If you wish to continue care with your current physician, a customer service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Non-Network Providers

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

If you choose to receive services from a non-network provider, you can still limit your out-of-pocket costs if the provider participates in our Traditional plans. If you use Blue participating providers outside the PPO network:

- The provider will bill us directly for your services.
- You will not be billed for any differences between our approved amount and their charges.

If you use a provider who **does not participate** with Blue Cross Blue Shield, you may be responsible for any difference between the provider's charge and our approved amount and

may need to file your own claims. When you use nonparticipating providers, we will send you our approved amount, less out-of-network deductible and co-payments. You are responsible for paying the provider. ***Note:*** When you go to a nonparticipating hospital, payment is limited to $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 any applicable deductibles and co-payments.

BlueCard PPO Program

When you need medical care **outside of Michigan,** you can receive in-network benefits by using the BlueCard PPO program. Simply call the toll-free number below and you'll be directed to the nearest BlueCard PPO provider. BlueCard PPO providers bill their local Blue Plan for any covered services you receive. The local Blue Plan does not reduce its payments to the BlueCard PPO providers by the out-of-network deductible and/or co-payments. You are responsible only for the in-network deductible and co-payments *(if applicable)* and for services not covered by your plan.

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

1. Call **1-800-810-BLUE (2583)** any day of the week. You will be given the name of the nearest **PPO** physician or hospital.

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

2. Show your BCBSM ID card and remind the provider you are covered under the BlueCard program and to **include the XYP alpha prefix** on all claims.
3. Pay applicable deductibles and co-payments required by your plan.

You won't be expected to pay any out-of-network co-payments or deductibles if:

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

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

Care Out of the Country

Your coverage applies no matter where you are only if:

- The hospital is accredited
- The physician is licensed

Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell us if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. We 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 co-payments that may apply.

How Your Community Blue PPO Plan Works

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

- When a PPO physician provides or refers your hospital and medical services, it is called "In-Network."
- When a PPO physician does not provide or refer your services, it is called "Out-of-Network." Each person enrolled in a Community Blue PPO plan is entitled to up to $1,000 annually for all preventive services (not covered out-of-network)

In-Network Guidelines

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

Referrals

Referral care services are services received from a provider not part of the Community Blue PPO network, **but coordinated by your PPO physician.**

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

PPO Network Exceptions

The following type of services are covered at the in-network level of benefits when performed by a Blue Cross Blue Shield of Michigan participating provider:

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

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

Emergency Care

When you think 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 only at the in-network level for approved diagnoses. ***Note:*** Follow-up care is not considered emergency care.

Your In-Network Deductible

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

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

The in-network deductible does not apply to:

- Preventive care services in a PPO network physician's office
- Covered services received in a PPO network physician's office
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office.
- Services subject to a fixed dollar co-payment
- Chiropractic spinal manipulation
- Pre-natal and post-natal care visits
- Allergy testing and therapy
- Injections
- Hospice care benefits

Your In-Network Co-payments

You are responsible for the following fixed dollar co-payments, which do not apply toward your deductible or co-payment maximum:

- $20 for office visits which includes urgent care visits and office consultations

- $50 per visit for all hospital emergency room treatment whether received in- or out-of-network

Reminder: The $50 co-payment will be waived if you are admitted into the hospital or if your care was required for treatment of an accidental injury. Once you have met your in-network deductible *(if applicable),* you will be responsible for the following co-payments:

- 20% co-payment for general services

Private Duty Nursing Co-payment

50% co-payment for private duty nursing

The in-network percent co-payment does not apply to:

- Hospice care benefits
- Preventive care services in a PPO network physician's office
- Covered services received in a PPO network physician's office
- Chiropractic spinal manipulation
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Services subject to a fixed dollar co-payment
- Pre-natal and post-natal care visits
- Allergy testing and therapy
- Injections

In-Network Co-payment Maximum

After you have paid **$1,500** per member or **$3,000** per family in-network and out-of-network percentage co-payments, you do not need to pay any further **in-network co-payments** for the rest of that year. However, you are still required to pay fixed dollar co-payments and percentage co-payments for mental health care, substance abuse care, and private duty nursing.

The following **cannot** be used to meet your co-payment maximum:

- Deductibles (in-network and out-of-network)
- Fixed dollar co-payments
- Private duty nursing co-payments
- Charges for non-covered services
- Charges in excess of our approved amount

Out-of-Network Guidelines

When you select services from providers who are not in the PPO network (out-of-network), you will be responsible for satisfying the out-of-network deductible and co-payments. No preventive care services are covered out-of-network. You are responsible for the following deductibles and co-payments when your care is received out-of-network.

Your Out-of-Network Deductible

Your coverage requires a **$1,000** per member or **$2,000** per family deductible before payment will be made for out-of-network benefits. This deductible is required each calendar year. When one individual has met the out-of-network deductible, benefits are payable for that individual. Out-of-network services for the remaining family members will be paid when the full family deductible has been met. ***Note:*** Out-of-network deductible amounts also apply toward the in-network deductible *(if applicable)*.
The out-of-network deductible does **not** apply to the following services:

- The initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Referrals to an out-of-network provider by a network provider
- Home health care agencies
- Freestanding substance abuse treatment programs
- Ambulance providers
- Durable medical equipment providers
- Prosthetic and orthotic suppliers
- Freestanding physical therapy facilities
- Ambulatory surgery facilities
- Skilled nursing facilities
- Private duty nursing
- Hospice care

Your Out-of-Network Percent Co-payments

After you have met your out-of-network deductible, you are responsible for the following co-payments:

- 40% co-payment for general services
- 50% co-payment for private duty nursing

Out-of-Network Co-payment Maximum

After you have paid $3,000 per member or $6,000 per family in out-of-network co-payments for general services, you do not need to pay any further out-of-network co-payment for the

rest of that year. However, you are still required to pay fixed dollar co-payments and percentage co-payments for private duty nursing.

Note: Out-of-network co-payments also apply toward the in-network co-payment maximum.

The following services **cannot** be used to satisfy your out-of-network co-payment maximum:

- Deductibles, in-network or out-of-network
- Fixed dollar co-payments
- In-network percentage co-payments
- Private duty nursing co-payments
- Charges for non-covered services
- Charges in excess of our approved amount

Community Blue PPO Hospital Coverage

This section explains your Community Blue PPO benefits. Please check each section of this booklet carefully for a complete explanation of your benefits. ***Important:*** Unless otherwise indicated, all services described in this section are subject to both in-network and out-of-network deductibles and co-payments listed in Section 5. Remember, some services listed in this section are not covered out-of-network.

Basic Hospital Coverage

Medical Necessity

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

- The covered service is for the treatment, diagnosis, or symptoms of an injury, condition or disease.
- The service, treatment or supply is **appropriate** for the symptoms and is consistent with the diagnosis.
- Appropriate means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
- For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross Blue Shield of Michigan.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment Programs.

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

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

Pain Management

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

Payment of Benefits

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

Hospital Benefits Inpatient

Note: If you choose to receive services from a **nonparticipating hospital,** payment is limited to $70 per day for inpatient services in acute care hospitals, $15 per day in specialty hospitals, and $25 per visit for outpatient hospital services.

Room and Board

Your benefits include the cost of a semi-private room; use of specialty care units such as intensive, burn, or cardiac care; meals and special diets; and general nursing care. However,

the cost of a private room is not covered. If you request a private room, your coverage will pay the cost of a semi-private room. You will be required to pay the difference.

General Medical Care Days

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

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

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

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

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

Inpatient Mental Health and Substance Abuse Treatment Care

Your coverage provides benefits for inpatient mental health and inpatient substance abuse services:

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

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

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

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

Important: Inpatient mental health care and substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. Determination of criteria for Severity of Illness and Intensity of Service may be made by the treating facility for the first two admissions per calendar year. If you are not sure that the criteria will be met, please have your physician call our Mental Health Precertification Unit at **1-800-762-2382** for guidance.

Hospital Services and Supplies

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

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

Hospital Benefits Outpatient

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

Emergency Medical Care in the Emergency Room

Your benefits include the initial exam and treatment of accidental injuries or conditions determined by Blue Cross Blue Shield of Michigan to be medical emergencies (see **Glossary** for definitions).

The following are not considered emergency care:

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

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

Pre-Admission Testing

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

Physical, Occupational and Speech Therapy

Benefits are payable when provided in:

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

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

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

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

Your therapy must:

- Be prescribed by the patient's attending physician
- Require the assistance and supervision of the appropriate licensed therapist

- Be designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury
- Be given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered therapy are:

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

Your coverage does not pay for:

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

Outpatient Substance Abuse Treatment

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

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

Reminder: These services are subject to a percentage co-payment as well as the annual dollar amount designated by state law. Since the state mandated substance abuse amount is adjusted annually, you should call our Customer Service Office for the current benefit amount.

Outpatient Mental Health

Services are payable in **participating** outpatient mental health care facilities. Benefits include:

- Counseling services provided by a physician, a fully licensed psychologist, or by the facility's staff
- Family counseling for members of the patient's family
- Ancillary services for patients who are admitted and discharged on the same day of treatment
- Prescribed drugs given by the facility in connection with treatment
- Electroshock therapy when administered by or under the supervision of a physician, other than the physician giving the electroshock therapy
- Psychological testing by a physician, fully licensed psychologist, or a limited licensed psychologist when prescribed and billed by a physician or fully licensed psychologist

Chemotherapy

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

Hemodialysis

Hemodialysis services are covered to treat acute kidney failure and end stage renal disease (ESRD). You can receive treatment in the outpatient department of a hospital or in a licensed facility. You can also receive dialysis services in the home if the owner of the patient's home gives the hospital prior written permission to install the equipment. Your physician must arrange for home hemodialysis and all services must be billed by a participating hospital that has an approved hemodialysis program. Benefits include cost of the equipment, installation, training, and necessary hemodialysis supplies.

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

Alternatives to Hospital Care

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

Home Hemophilia Program - Your benefits include all medications and medical supplies needed for in-home treatment for hemophilia, including syringes, needles and the antihemophilic factor. Your physician must prescribe all services and all services and supplies must be billed by a participating hospital. Your benefits also include training the patient or a

family member on how to inject the antihemophilic factor, when the training is provided through an approved facility.

Home Health Care - To receive benefits under the Home Health Care program, a physician who certifies that the patient is confined to the home due to illness, must prescribe and submit a detailed treatment plan to the home health care agency. Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

- Part-time health 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
- Social services and nutritional guidance when requested by the patient's physician
- Physical, speech, and occupational therapy (up to a combined maximum of 60 visits per member per calendar year; this benefit maximum renews each calendar year)
- Nursing care when supervised by a registered nurse employed by the home health care agency

Important: We do not pay for general housekeeping services, for transportation to or from a hospital or other facility, for elastic stockings, sheepskin or comfort items such as lotion, mouthwash, body powder, etc., for physician services, and for custodial or non-skilled care.

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

Your coverage **does not pay** for:

- Custodial care
- Care for senility or mental impairment

Hospice Care - A hospice is an agency that is primarily involved in providing care to terminally ill individuals and can be used as an alternative to hospitalization. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less. You may apply for hospice care benefits only after discussion with and referral by your attending physician. Your request must be in writing to the hospice agency **and all hospice services must be arranged through an approved hospice provider.**

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

Levels of Care - The hospice program provides four levels of care:

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

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

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

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

Hospice Services - The following benefits are payable under the hospice program up to the dollar maximum amount that is reviewed. and adjusted annually. Please call 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 us

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: There is a separate dollar maximum for services provided by a physician who is not part of the hospice team. Please call us for information about the current dollar maximum.

Individual Case Management - is a voluntary program through which care is provided outside a hospital setting. The program is designed to assist an individual whose cost of medical care is very high or whose care would exhaust available benefits. A case management analyst evaluates patients for ICMP who have been referred by a hospital, physician, or a family member. When the patient is accepted as a candidate for ICMP, an analyst works with the patient's family and physician to develop a personal treatment plan, called the Alternative Benefit Plan. The plan can include services not normally included in your coverage. The analyst also identifies all payable services and payment arrangements related to the plan.

Whenever possible, we will identify more than one provider for services recommended in the plan. The patient and family then have the option to select the provider. After reviewing the Alternative Benefit Plan documents, the patient and family can decide whether or not to accept the plan. Participation is entirely voluntary. Once the treatment plan is implemented, participation can be canceled if:

- The patient's condition no longer requires the extra benefits documented in the Alternative Benefit Plan.
- The total amount paid under the Alternative Benefit Plan exceeds the amount that would be payable under the patient's regular hospital coverage.

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

Human Organ Transplants

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

Organ and Tissue Transplants

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

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

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

Bone Marrow Transplants

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

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

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

Reminder: HLA (human leukocyte antigens) genetic markers are specific chemical groupings of many body cells, including white blood cells used to detect the constitutional similarity of one person to another. Your coverage also includes transplants of the patient's own bone marrow (**autologous**) and/or transplanting the patient's own peripheral blood stem cells when used to rescue a patient after receiving high doses of chemotherapy. The transplant cannot be considered experimental or investigational.

Only the following conditions are covered:

- Acute lymphocytic leukemia
- Acute non-lymphocytic leukemia
- Ewing's sarcoma
- Germ cell tumors of ovary, testes, mediastinum and retroperitoneum
- Hodgkin's disease (stage III or IV)
- Medulloblastoma
- Metastatic breast cancer (stage IV)

- Multiple myeloma
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (intermediate or high grade)
- Primitive neuroectodermal tumors
- Wilms' Tumor

Payable benefits for bone marrow transplants include:

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

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

Your coverage does **not** pay for:

- Any services related to or for allogeneic bone marrow transplants and/or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements.
- Purging of and/or positive stem cell selection of bone marrow stem cells, or peripheral blood stem cells.
- Harvesting and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplant within one year.
- Health care services provided by persons who are not legally qualified or licensed to provide such services.
- Services that are not medically necessary (see **Glossary** for a definition of medical necessity.)

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

Specified Human Organ Transplants

Benefits are limited to a $1 million maximum for each type of human organ transplant.

- Facility and professional services.
- Anti-rejection drugs and other transplant-related prescription drugs, as needed.

Payment will be based on the amount we determine to be reasonable and necessary.

Our payment for the drugs is limited only by the $1 million maximum.

- Medically necessary services needed to treat a condition rising out of the organ transplant surgery if the condition occurs during the benefit period, and is a direct result of the organ transplant surgery. We will pay for any medically necessary service needed to treat a condition as a result of the organ transplant surgery, if it is a benefit under any of our certificates.
- Up to $10,000 for travel, meals and lodging directly related to pre-approved services. We will pay the cost of transportation to and from the designated transplant facility for an adult patient and one companion eligible to accompany the patient (or two companions if the patient is under age 18 or if the transplant involves a living related donor). Within the $10,000 we will pay the reasonable and necessary costs of meals for the patient and eligible companion(s), up to a combined maximum of $40 per day, and the costs of lodging for the eligible companion(s).
- Reasonable and necessary cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ. The total payment for all services combined for each transplant will not be more than $1million maximum.

Your specified transplant coverage does not cover:

- Non-covered services.
- Living donor transplants other than liver and lobar lung transplants.
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin).
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval.
- Transplant procedures and related services that are not pre-approved.
- Transplant surgery that is not performed in a designated facility.

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

Physician Benefits

Your coverage provides the following benefits for physician care:

Medical Necessity

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

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

Preventive Services

The following preventive services are covered when they are received in-network. Preventive benefits are payable up to a maximum dollar amount on a per member per calendar year basis. **These services** *are not covered out-of-network,* with or without a referral.

Health Maintenance Exams - covers one per member per calendar year which includes a comprehensive history and physical examination, and the following laboratory and radiology procedures:

- Chemical profile
- Complete blood count
- Urinalysis
- Chest X-ray
- EKG

Colonoscopies - as deemed medically necessary.

Gynecological Exams - covers one per member per calendar year.

Pap Smear Screening (laboratory services only) - covers one per member per calendar year when prescribed and performed by a PPO physician. More frequent pap smears are covered because of the suspected or actual presence of a disease or when required as a post-operative procedure.

Well-Baby and Child Care Visits - covers routine visits to a physician to monitor the development and well-being of children. These visits are covered through age 15 as follows:

- Six visits per year through age 1
- Two visits per year, age 2 through 3
- One visit per year, age 4 through 18

Immunizations - We pay for childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics. Benefits include the following immunizations through age 16:

- Up to five doses of diphtheria, tetanus, and pertussis (DTP) vaccines
- Up to six does of polio vaccine
- Up to two doses each of measles, mumps, and rubella vaccines
- Tetanus Immune Globulin (human) and Antitoxins (horse serum)
- Poliomyelitis vaccine
- Diphtheria toxoid
- Up to three doses of Hepatitis B vaccine
- Up to four doses of Hib (Hemophilia B) vaccine
- Chicken pox vaccine

Note: We periodically update our list of eligible immunizations. Please call your local Customer Service office to inquire about immunizations not listed.

- **Fecal Occult Blood Screening** - covers one per member per calendar year.

- **Flexible Sigmoidoscopy Exams** -covers one per member per calendar year.
- **Prostate Specific Antigen (PSA) Screening** - covers one per member per calendar year.
- **Mammography Screening** – covers one per member per calendar year
- **Prescribed Contraceptive Devices -** covers physician-prescribed contraceptive devices such as diaphragms and IUDs, and their insertion.

Office Visits

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

Allergy Services

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

Chiropractic Services

Your benefits include the following chiropractic services:

- **New Patient Office Visits** - covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.
- **Office Visits** - covers one per member every calendar year for established patients.
- **Chiropractic Traction** - number of payable visits is determined by your physical therapy benefit.
- **Chiropractic Manipulation** - limited to one per day, up to a maximum of 24 medically necessary visits each calendar year.

Hearing Care Benefits

Your benefits include the following Hearing Care Services when they are received in-network up to the benefit maximum of $1,500 every 36 months:

- Audiometric Exam
- Hearing Aid Evaluation Test
- Conformity Test
- Ordering, and fitting the hearing aid(s) (one or both ears)

Statement of Rights Under the Newborn's and Mother's Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket cost so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization of prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Fund Office.

Limitations

Pregnancy Expense Benefits are not payable for pregnancy expenses incurred by a dependent child.

Pregnancy Expense Benefits are subject to all the limitations which apply to individual benefits payable for any sickness or injury, including the General Plan Exclusions and Limitations.

Maternity Care

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

Surgical Services

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

- When surgeries are through **different** incisions, we pay the approved amount for the most costly procedure and one half of the approved amount for the less costly procedure.

- When the surgeries are through the **same** incision, they are considered related and we pay the approved amount for the more difficult procedure.

Reminder: Network and participating providers accept our approved amount as payment in full. However, nonparticipating providers may bill you for the difference.

- **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars, and for correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- **Dental surgery** is covered only for the removal of impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition exists, such as a heart condition.
- **Breast reconstruction surgery** is covered for:
- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- **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 certified registered nurse anesthetists. We do not pay for local anesthesia.

Temporomandibular Joint Syndrome (TMJ) Or Jaw-Joint Disorder

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

If you are not sure that your prescribed treatment will be covered, ask your physician to contact Blue Cross Blue Shield of Michigan for approval **before** treatment begins.

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

Inpatient Medical Care

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

Inpatient and Outpatient Consultations

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

Diagnostic and Radiation Services

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

- **Diagnostic radiology** - includes x-rays, ultrasound, radioactive isotopes, and Magnetic Resonance Imaging (MRI) and CAT scans of the head and body when performed for an eligible diagnosis.
- **Laboratory and pathology tests.**
- **Diagnostic tests** - includes EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies.
- **Radiation therapy** - includes radiological treatment by x-ray, isotopes, or cobalt for a malignancy.
- **Mammography** - **diagnostic** Mammograms are covered if prescribed by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.

Other Covered Services

Your coverage includes the following services:

Durable Medical Equipment (DME) - Benefits include rental or purchase (whichever is less expensive) and repair of durable medical equipment when prescribed by a physician. The prescription must include a description of the equipment and a diagnosis.

For rental equipment, a new prescription must be written when the current prescription expires.

Important: We do not pay for exercise and hygienic equipment, for comfort and convenience items, for self-help devices, such as elevators, for deluxe equipment, such as motorized wheelchairs unless medically necessary and required so the patient can operate the equipment themselves, and for experimental or investigational equipment.

Medical Supplies - We pay for medical supplies and dressings for use in the home when prescribed by a physician for the treatment of a specific medical condition.

Prosthetic and Orthotic Appliances - We pay 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, service and fitting charges. Adjustment or replacement of eligible appliances is payable only when required because of wear, growth or change in the patient's condition.

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

Important: We do not pay for non-rigid devices and supplies such as elastic stockings, garter belts, arch supports, corsets, shoe inserts and supportive appliances for the feet, hearing aids and hair prosthesis such as wigs or hair implants. Corrective shoes are payable **only** when required to correct a physical defect and are attached to a leg brace.

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

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

Your coverage **does not pay for:**

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

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

What's Not Covered

Your Community Blue PPO coverage does not cover the following:

- Pre-marital or pre-employment examinations.
- Care and services available at no cost to you in a veterans, marine, or other federal hospital or any hospital maintained by any state or governmental agency.
- Medically necessary services received in an inpatient basis that can be provided safely in an outpatient or office setting.
- Custodial care, rest therapy, and care in nursing or rest home facilities.
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists.
- Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than direct surgery on the jaw joint, arthrocentesis (injections) or X-rays.
- Eye examinations and eyeglasses or other corrective vision appliances.
- Hospital admissions that began **before** the effective date of coverage.
- Hospital admissions that begin **after** the coverage termination date.
- Medical services or supplies provided or furnished while coverage is not in effect (that is **before** the effective date of coverage or **after** the coverage termination date).
- Health care services provided by persons who are not legally qualified or licensed to provide such services.
- Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions.
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), or basal metabolism tests.
- Items for the personal comfort or convenience of the patient.
- Psychiatric services after determination that the patient's condition will not respond to treatment.
- Psychological tests for vocational guidance or counseling.
- Services and supplies that are not medically necessary according to accepted standards of medical practice.
- Services provided through a medical clinic or similar facility provided or maintained by an employer.
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund.
- Care and services 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 the member 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 appearances, except as specified in this booklet.
- Treatment of a condition caused by military action or war, declared or undeclared.
- Services, care, devices or supplies considered experimental or investigational.
- Services for which a charge is not customarily made services for which the patient is not obligated to pay or services without cost.
- Transsexual surgery.
- Tests other than those identified in the benefit section that are not required in, and related to the diagnosis of an illness of injury.
- Dialysis services after 33 months of ESRD treatment.
- Services that are not included in your plan coverage documents.
- Transportation and travel except as specified in this handbook.
- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan.
- Screening services, unless otherwise stated, excluding mammograms.
- Deductibles or co-payments paid by the member under any other certificate.
- Physical therapy services performed by a chiropractor.
- Services, care, supplies, or devices not prescribed by a physician.
- Services, care, supplies, or devices for treatment of injury or illness relating to a motorized vehicle accident, as described in General Exclusions and Limitations below.
- Services provided during non-emergency medical transport.

Other Coverage
Prescription Drug Coverage

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

What's Covered

You have coverage for:

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

- Lifestyle drugs such as those that treat sexual impotence or infertility, or help in weight loss. Contact BCBSM for details

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

Generic Equivalent Drugs

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

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

- If your doctor prescribes a brand name medication to be "dispensed as written" when a generic alternative is available. The doctor must write "Dispense as Written" or "DAW" on the prescription.
- If you request the brand name drug. You must pay the difference in cost between the brand name drug and the generic equivalent, in addition to your co-payment.

Co-Branded Drugs

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

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

Your Co-payment

Your co-payment is as follows:

- $15.00 for generic drugs.

- $30.00 copayment whenever a member receives brand name drugs, even if the prescription indicates "DAW" or if there is no generic equivalent drug available.

Choosing Your Pharmacy

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

Network Pharmacy

A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.
Important: Pharmacies outside of Michigan must use the MedImpact BIN and PC number below to verify your eligibility, not the five-digit group number on your ID card.

MedImpact Rx BIN 003585/Rx PCN 23615

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

Non-Network Pharmacy

Pharmacies not part of the Preferred Rx or MedImpact network are called non-network. If you go to a non-network pharmacy, you, not the pharmacist, will need to file your claim for payment. You'll receive 75% of our approved amount less your co-payment. You are responsible for any difference between the cost of the prescription or refill and our payment.

Mail Order Prescription Drugs

Your mail order prescription drug program is available for long-term and ongoing prescription drug needs. If you are taking medication on a regular basis, ordering your prescriptions through our mail order plan is convenient. In addition to mailing your prescriptions to the mail order pharmacy, your physician can phone in or fax your prescription orders. Refills on your mail order prescriptions can be ordered by mail, telephone, or the Internet.

When prescribed by your physician, you can order up to a 90-day supply (three months) of medication by mail from ESI-Medco Rx Services and pay the applicable co-payment for each prescription or refill as follows:

- Up to 33-day supply - your co-payment
- 31 to 90-day supply - double your co-payment

Ordering from ESI-Medco Rx Services requires no claim forms. Your medication is delivered to your home, postage-paid, within 10 to 14 business days from the date you mailed your order. If you have questions, you can call ESI-Medco Rx Services at **1-800-903-8346.** You can also visit their Internet Web site at **www.merck-medco.com** to order refills, check on the status of your mail order prescriptions, or request mail order envelopes.

Retail Prescription Drugs- 90 Day Supply

A 90-Day supply of any maintenance drug may be obtained at your local Retail Pharmacy for the co-payment cost of only a 60-Day supply. This option makes it more convenient and cost-effective for participants that utilize this benefit. New prescriptions must be filled for two single month supplies before you will be able to take advantage of the 90-day option, to make sure the new prescription works for you. For more information on which drugs appear on the Maintenance Drug listing, visit www.bcbsm.com.

Pharmacy Savings Program

The Fund has a Pharmacy Savings Program administered by Health Plan Advocate (HPA). Through this program, HPA will assist with your prescription drug needs by identifying drug manufacturer assistance coupons to save money for you and the Fund.

Please note the following program details:

- All prescription drugs that (1) cost $400 or more and (2) have a drug manufacturer assistance coupon available (a “program-eligible drug”) will automatically be included in the program. For all other prescription drugs, the standard co-pays described in the Plan and Summary Plan Description, and Summary of Benefits and Coverage, will apply, including prescription drugs that cost $400 or more for which there is no manufacturer coupon.

- If you or one of your dependents is taking a program-eligible drug, HPA will contact you to assist you with participation in the program.

- For those who respond to HPA and participate in the Pharmacy Savings Program, **your final cost for your program-eligible drugs will be $0**. A small “point-of-sale” co-pay might apply, which will be reimbursed to you by the Fund.

- For those who decline to respond to HPA and participate in the program, a co-pay of up to 50% will apply to your program-eligible drugs.

- If you or your any of your dependents has been identified as eligible for the program, be sure to respond to HPA so you can avoid the up to 50% prescription drug co-pay and take advantage of the cost savings and advocacy benefits of the Pharmacy Savings Program.

For program-related or general questions, HPA can be reached by phone at (866) 680-4859, ext. 206, or by email at pharmsavings@healthplanadvocate.com.

What's Not Covered

Your Prescription Drug coverage does not cover:

- Drugs that cost less than your co-payment
- Administration of covered drugs or any covered drug entirely consumed at the time and place of the prescription
- Refills not authorized by a physician
- Any medication that does not require a prescription, except insulin
- Therapeutic devices or appliances, even if prescribed by a physician (for example, support garments regardless of their intended use)
- More than a 34-day supply of a covered drug, except as noted when purchased through the 90-day retail program, or mail order program for up to a 90 day supply
- Refills dispensed after one year from the date of the original order
- Prescription drugs that are used primarily for improving appearance rather than for treating a disease
- Diagnostic agents
- Any vaccine given solely to resist infectious diseases
- Any drug we determine to be experimental or investigational
- Drugs or services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which you are eligible
- Drugs or services obtained before the effective date or after the contract ends
- Nonpreferred co-branded drugs, unless they are preauthorized
- Elective drugs

Medicare Coverage for Eligible Members

Medicare Coverage

Medicare is a federal health care program designed to provide health care benefits to persons who are 65 or older, to persons who have End Stage Renal Disease (ESRD) and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a "beneficiary." You become eligible for Medicare when you are 65 (or earlier if you are disabled or have ESRD). If you are eligible by reason of age, you may enroll at any time during a seven-month period. This period begins three months before the month in which you reach 65, and includes the actual month of your birthday and the three months following your birthday month. During this period, you must apply for Medicare through your local Social Security Administration office.

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

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

Employed Persons Aged 65 or Older

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

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

The following explains these options:

Option 1

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

Important

If you continue to be covered by your group health plan as your primary plan, you should still apply for Medicare benefits, especially Part A. Remember: Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide **additional** benefits to your group coverage.

- 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.

Part D of Medicare, the prescription drug insurance, is available for a monthly premium. Medicare Part D is not required by the Plan.

Option 2

You may elect to opt out of your group health plan, which will make Medicare your primary health care plan. However, if you select this option, federal regulations prohibit your employer from providing you with any coverage that is secondary to Medicare or have any involvement with individual Medicare Supplemental coverage. You must file a written notice with your employer, with Medicare and with us if you choose this option.

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

Medicare Advantage Coverage

If you have supplemental coverage through the Fund's Medicare Advantage program, it works with your Medicare coverage to extend your health care benefits.

What's Covered

You have coverage for the following:

- Part A benefits
    - **Inpatient hospitalization** – covers your Medicare Part A deductible and coinsurance required from the 61st day through the 90th day of a hospital admission. It also extends the number of your inpatient days to 365.
    - **Lifetime reserve days** – covers the daily coinsurance required by Medicare.
    - **Skilled nursing care** – covers the daily coinsurance required by Medicare for days 21 through 100.
- Part B benefits
    - **Physician Services and Outpatient Care** – covers services in the same manner as participants eligible other than through Medicare, with limitations and exclusions set forth in the Plan

What's not Covered

Your Medicare Advantage coverage **does not** cover:

- Custodial nursing care (such as help with walking, getting in and out of bed, eating, dressing, bathing and taking medications) at home or in a nursing home.
- Intermediate nursing care in a nursing home.
- Private duty nursing or skilled nursing care not approved by Medicare.
- Physician charges that are more than Medicare's allowed amount.
- Injury or sickness covered by Workers Compensation.
- Admissions or care provided by a government-owned or –operated hospital unless payment is required by law.
- Admissions that begin before the effective date of coverage.
- Admissions that begin after the termination date.
- Medical care, services or supplies provided or furnished while coverage is not in effect (that is, before the effective date of coverage or after the coverage termination date).
- Drugs other that prescription drugs furnished during your stay in a hospital or skilled nursing facility.
- Dental care, dentures, routine physicals and immunizations, cosmetic surgery, routine foot care and examinations for eyeglasses or hearing aids.

To File a Claim

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

To file your own claim, follow these steps:

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

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

Important: If you receive medical services out of the country, try to get all receipts itemized in English.

1. Cash register receipts, canceled checks, or money order stubs may accompany your itemized statement, but may not substitute for an itemized statement.

2. Make a copy of all items for your files and send the original to us at the address listed in

Section 1. It is important that you file claims promptly because most services have a two-year filing limitation.

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

The example below shows the information we require in order to review your claim:

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

If the patient does **not** have Medicare coverage, send all of the claim information to:
Blue Cross Blue Shield of Michigan
P.O. Box 2888
Detroit, Michigan 48231

Explanation of Benefit Payments (EOBP)

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

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

If you see an error, contact your provider first. If they cannot correct the error, call the customer service number on your EOBP.
If you think your provider is intentionally billing us for services you did not receive, or that someone is using your card illegally, contact our Anti-Fraud Hotline:

In Michigan, call: 1-800-482-3787

Outside Michigan, call: 1-313-225-8100. Your call will be transferred to our Anti-Fraud Unit.

Your call is strictly confidential. By working together, we can help keep health care costs down.

Incorrect Benefit Payments

Every effort is made to process your claims promptly and correctly. If your claim for benefits is denied in whole or in part, we will notify you of the denial in writing. To appeal the denial or payment, you may either call or write us using the number or address in

Section 1. Be sure to state the reason for your appeal and furnish us with all information supporting your position. Once we receive your appeal, we will review it and respond to you within 60 days after we receive the appeal.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans.

Your Blue Cross Blue Shield health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100% of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

How COB Works

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

- Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.
- Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services - up to the total allowable amount determined by the carriers.

Guidelines to Determine Primary and Secondary Plans

Contract Holder Versus Dependent Coverage

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

Contract Holder (Multiple Contracts)

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

Dependents (The "Birthday Rule")

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

Children of Divorced or Separated Parents

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

1. Plan of the custodial parent.
2. Plan of the custodial parent's new spouse (if remarried).
3. Plan of non-custodial parent.
4. Plan of non-custodial parent's new spouse.

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

Filing COB Claims

Remember to ask your health care provider to submit claims to your primary carrier first.
If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to the secondary carrier. When you submit claims to Blue Cross Blue Shield of Michigan 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
   600 East Lafayette Blvd
   Detroit, MI 48226-2998
   Attn: COB Department #B570

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 your employer immediately. We may periodically ask you to update your COB information. Please help Blue Cross Blue Shield serve you better by responding to requests for COB information quickly.

Subrogation

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

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

Glossary - Terms You Should Know

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

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

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

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

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

Approved Amount - The Blue Cross Blue Shield of Michigan maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and co-pays are deducted from the approved amount. **For Prescription Drugs,** the approved amount is the lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug or service. The drug cost and dispensing fee are set according to our contracts with the pharmacy. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Co-pays that may be required of you are subtracted from the approved amount before we make our payment.

Approved Facility - A hospital or clinic that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care, or physical therapy. Approved facilities **must** meet all applicable local and state licensing and certification requirements. Approved facilities must be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. These facilities must also meet all applicable local and state licensing and certification requirements and have been approved as a provider by Blue Cross Blue Shield of Michigan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Negotiated Price - In most cases, the "negotiated price" is a simple discount arrangement. Some Blue Plans use an estimated price that factors in expected settlements with health care providers or provider groups. Or "negotiated price" may reflect average expected savings, which the Blue Plan periodically adjusts to correct for past over- or underestimation of prices. In addition, a few states require their local Blue Plan(s) to calculate payments in such a way that the entire discount may not be passed on to us for each claim. When you receive health care services in these states, your payment and any deductible or co-pay will be based on the method required by law.

Network Pharmacies - Pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Preferred Rx network (in Michigan) or Merck-Medco Managed PAID Prescriptions Coordinated Care Network Level III (CCN III) network (outside Michigan). Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

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

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

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

Occupational Therapy - Treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints.
- Help the patient apply the restored or improved function to daily living.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We, Us, Our - Used when referring to Blue Cross Blue Shield of Michigan.

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

Notes

These are the codes for your Certificates and Riders and are for internal use by BCBSM:

C 4398-BONE MRRW TRANS C 5220-SUBR02
C 5227-HMN C 5423-END STAGE RENAL
C 5821-ASFP C 6003-ICMP
C 6225-COMM BLUE BASIC C 7292-PTFS-COMPS
C 9770-GRP CONTINU OPT C 993009-GLE-1
S 3687-CERT NURSE PRAC S 4398-BONE MRRW TRANS
S 5216-ECIP S 5220-SUBR02
S 5385-CRNA S 5423-END STAGE RENAL
S 6217-PTS-PSG S 6225-COMM BLUE BASIC
S 6600-CNM S 6603-CB-PCB
CBC20P CBC40NP
CBCMNP30000 CBCMP$1500
CBCD$1000 CBD$500NP
S 7469-RAPS S 9770-GRP CONTINU OPT
S 9973-PCD BCP
BCP-PPO MLOS
FC

Group No:00000/000 Eff:96/11/01 Dist.Ofc.B:200 Pr:07/26/2000 Qty:102

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

To obtain these certificates and riders, you must make your request *in writing* to:

Blue Cross and Blue Shield of Michigan
Mail Code 1927
500 Lafayette East
Detroit, Michigan 48226

Be sure to include the subscriber's first and last name, address, contract number, and group number as it appears on the BCBSM identification card.

SECTION III

WEEKLY ACCIDENT AND SICKNESS BENEFITS (LOSS OF TIME)

If an Employee while actively employed becomes totally disabled from non-occupational accidental bodily injury or sickness, the Plan will pay a Weekly Benefit of $350 beginning with the first date of disability specified, and continue while you remain totally disabled, subject to the maximum period of benefits of twenty-six (26) weeks during any one period of disability. If the disability is related to an occupational injury or a motorized vehicle, there is no monetary benefit available.

Active Employees Only

Application for Loss of Time Benefits

For the Fund to consider Loss of Time Benefits, you must submit a fully completed claim form.

1. Both you and the physician must complete the form.
2. If possible, have your present Employer complete its portion of the claim form. If you were laid off at the time of disability, indicate this on your claim form.
3. The Fund must receive a Return to Work Notice completed by your physician.

Period of Disability

All disability absences will be considered as having occurred during a single period of disability unless evidence acceptable to the Trustees is furnished that:

1. The cause of the latest disability absence cannot be connected with the causes of any prior disability absences, and the latest disability absence occurs after return to active work for at least one day; or
2. The causes of the latest disability absence can be connected with the causes of a prior disability, but the two were separated by a return to active work for at least two weeks. *Limitations*

No benefits are payable under this benefit provision for any period or day of disability for which the Employee is not under the regular care and attendance of a physician. A Chiropractor is not considered a physician for the purposes of disability benefits.

No benefits are payable under this benefit provision for any period on or after the date an Employee retires, even if such Employee would normally be considered eligible based on Employer contributions for hours worked before retirement.

The benefits provided under this provision are not assignable.

Weekly Accident and Sickness Benefits are also subject to all General Plan Exclusions and Limitations

SECTION IV

DENTAL CARE BENEFITS

When you or your Dependent incurs expense for dental care, the Plan will pay those expenses up to the reasonable and customary amount charged for all services, up to the benefit maximum of $1,500 per calendar year for each person over age 18. The Plan also requires co-payments for eligible types of care so you will share the cost of your treatment. Co-payment levels are specified for each group of eligible expenses.

Delta Dental Plan of Michigan

The dental program is administered by Delta Dental Plan of Michigan. Details of the dental benefits under the Plan are contained in the Summary of Dental Plan Benefits as described in the Appendix.

The Maximum Amount

All payments under Dental Care Benefits are limited to the benefit maximum amount for the type of care involved. The maximum amount applies to you and each of your eligible Dependents separately.

The maximum amount for Orthodontic Procedures is on a Calendar Year Basis. It is not renewed if eligibility is lost and then reinstated at a later date. The maximum amount for all other covered expenses applies to payments for treatment each calendar and so is renewed each January 1st. Benefits not used in a prior year cannot be carried forward to increase the maximum amount for the next calendar year.

How To Submit A Dental Claim

It is important that you notify your Dental Care Provider that all claims are to be submitted to the following address:

Delta Dental
P.O. Box 9085
Farmington Hills, MI 48333-9085

Treatment in Progress When Eligibility Terminates

The Plan will generally ***not pay*** for services or supplies furnished after the date you or your Dependent's eligibility terminates, even if the Claims Office has predetermined the payments for a treatment plan submitted before the termination date.

The Plan will pay for services or supplies related to the following covered expenses if the treatment is rendered during the calendar month immediately after the termination date and the following conditions are met:

1. A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the patient was covered under the Plan;
2. A crown if the dentist prepared the tooth for the crown while the patient was covered under the Plan; and
3. Root canal therapy if the dentist opened the tooth while the patient was covered under the Plan.

Limitations

Dental Care Benefits ***are not*** payable for:

1. Any service rendered, supply ordered or treatment plan begun before coverage became effective;
2. Treatment other than by a licensed dentist or licensed physician, except for services performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by a dentist;
3. Services or supplies that are primarily cosmetic in nature, including charges for personalization or characterization of dentures;
4. Replacement of a lost, missing or stolen prosthetic device;
5. Replacement or repair of an orthodontic appliance;
6. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer;
7. Services or supplies which are not necessary according to accepted standards of dental practice;
8. Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;
9. Any duplicate appliance or prosthetic device;
10. Athletic mouth guards;
11. A plaque control program (a service of instruction on the care of the teeth);

12. Periodontal splinting;
13. Services which are provided under other sections of this Plan;
14. Myofunction therapy (correction of harmful habits);
15. Charges associated with the initial installation of dentures or bridgework replacing a tooth or group of teeth which were lost when not eligible for coverage in this Plan until the person has been eligible for twelve (12) consecutive months;
16. Expenses for services other than those specifically indicated as covered;
17. Veneers;
18. Non-surgical T.M.J. treatment; and
19. Treatment of orthodontics (braces) after age twenty (20).

Dental Care Benefits are also subject to all General Plan Exclusions and Limitations and other Plan provisions, as well as Exclusions and Limitations in the Delta Dental Summary of Dental Plan Benefits.

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SECTION V

VISION CARE BENEFITS

When you or your Dependent incurs expense for Vision Care, the Plan will pay those expenses up to the maximum amount shown in the following section on a calendar year basis unless other limitations apply. There is **no deductible** required by the Plan before Vision Care Benefits become payable.

The Maximum Amount

Payments under the Vision Care Benefits are limited to the individual maximum as shown in the following description of benefits.

How To Submit A Vision Claim

It is important that you notify your Vision Care Provider, that all claims are to be submitted to the following address:

Michigan State Painters Insurance Fund
6525 Centurion Drive
Lansing, Michigan 48917
ATTN: Claims Processing

Covered Expense

Services or supplies must be provided by an Optician, Optometrist, or Ophthalmologist to be considered Covered Expenses. Typical services are shown below.

1. Vision Examination is payable at twenty-five dollars ($25) if performed by an Optometrist, or thirty-five dollars ($35) if performed by an Ophthalmologist, for one examination per calendar year.
2. Vision analysis may be done. Vision analysis includes:
    a. complete case history;
    b. measuring and recording of visual acuity, corrected and uncorrected;
    c. examination of fundus, media, crystalline lens, optic disc and pupil reflex for pathology, anomalies or injury, corneal curvature measurements, retinoscopy;
    d. fusion determination, distance and near, subjective determination, distance and near, and stereopsis determination, distance and near;

e. color discrimination and amplitude or accommodation;

f. analysis of findings, lens prescription (if needed); and

g. measuring and recording of visual acuity, distance and near, with new prescription if required.

3. Contact Lenses are payable up to a benefit maximum of ninety dollars ($90) per calendar year; lenses for spectacles up to a benefit maximum of sixty dollars ($60) per calendar year; and Frames up to a benefit maximum of sixty dollars ($60) per pair for one every twenty-four (24) months. Related services and supplies include:

   a. professional advice on frame selection;

   b. facial measurement, and preparation of specifications for optical laboratory and verifying and fitting of prescription glasses or contact lenses;

   c. re-evaluation and progress report after fitting new prescription and subsequent servicing.

Limitations

Vision Care Benefits are not payable for:

1. Non-prescription sunglasses;
2. Services, treatment or supplies related to medical or surgical treatment of the eyes;
3. Services, treatment or supplies, which are rendered or finished before the date a person becomes initially eligible or after the date a person's eligibility terminates.

Vision Care Benefits are also subject to all General Plan Exclusions and Limitations.

Laser Surgery to Correct Vision Deficiencies

Is a non-covered benefit under the Plan.

SECTION VI

DEATH AND DISMEMBERMENT BENEFITS

DEATH BENEFITS

If you die from any cause, a Death Benefit is payable in the amount of ten thousand dollars ($10,000) for eligible Active participants, and three thousand dollars ($3,000) for eligible Retired participants. The Death Benefit for Active participants is reduced by 35% at age 65, 55% at age 70, 70% at age 75, and 80% at age 80. The Fund Office must be provided with acceptable proof of death on forms acceptable to the Trustees.

Beneficiary Designation

You must file a written designation of Beneficiary with the Fund Office on a properly completed form. If you have not made an irrevocable designation of Beneficiary, you may name a new Beneficiary without your prior Beneficiary's consent, by filing a new form with the Fund Office. The change of Beneficiary will be effective retroactively to the date you sign the form, whether or not you are living when the Fund Office receives it. The Plan is not responsible for any payments made before the change of Beneficiary form is received. If you do not designate a Beneficiary or if your Beneficiary does not outlive you, the Death Benefit will be paid in the following order:

1. Spouse;
2. Children, including legally adopted children;
3. Parents;
4. Brothers and sisters; and
5. Personal Representative, Executor or Administrator of the Employee's estate.

If two (2) or more persons are entitled to the Death Benefit, they will share equally.

Following the entry of a judgment of divorce, it is presumed that a participant intended to revoke any designation of his or her former spouse as the participant’s designated Beneficiary unless:

a. the judgment of divorce affirmatively states that the divorced spouse remains the designated Beneficiary;

b. a Qualified Domestic Relations Order affirmatively states that the divorced spouse remains the designated Beneficiary; or

c. the participant completes a new designation of beneficiary form after entry of the judgment of divorce, which names the divorced spouse as the participant's designated Beneficiary.

If none of the above occurs after a divorce and no new beneficiary is designated, a Death Benefit will be paid as if the participant failed to designate a Beneficiary.

Notice of Claim

Written notice of the death of an Employee whose coverage has been continued under this provision must be given to the Fund Office within twelve (12) months of the date of death. If written notice is not given within such twelve (12) month period, the Plan will not be liable for any person on account of that death.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When accidental bodily injury that was caused directly and independently of all other causes by external, violent, and accidental means occurs and results in any of the following losses to the Insured individual within ninety (90) days after the date of the accident, the Plan will pay in addition to any other benefit provided by the policy:

a) The Principal Sum for loss of life, or

b) one-half of the Principal Sum for loss of one hand by severance at or above the wrist, or loss of one foot by severance at or above the ankle, or irrecoverable loss of sigh of one eye, or

c) the Principal Sum for loss more than one of the participants enumerated in paragraph (b) above;

The total payment for all such losses resulting from injuries due to the same accident shall not exceed the Principal Sum of ten thousand dollars ($10,000). If benefits are payable for loss of life, the Plan shall have the right and opportunity to have an autopsy conducted when it is not forbidden by Law.

The Principal Sum, as referred to herein, shall be the maximum amount of AD & D Principal Sum as noted in this section.

Points to Note About Accidental Death and Dismemberment Benefits

The Principal Sum is the maximum amount that would be paid to Active participants, for injuries to any one person resulting from any one accident. This means that if an Employee were to lose both hands and both feet in an automobile accident, the Employee would receive the Principal Sum only, not double the Principal Sum. This benefit is not payable to Retired individuals.

Accidental Death & Dismemberment Benefits will not be paid in the event of injury resulting from intentional self-mutilation, suicide, ptomaine poisoning, bacterial infections, or participation in war.

Accidental Death & Dismemberment Benefits will not be paid if loss of life, limb, or sign occurs more than ninety (90) days after the accident.

Accidental Death and Dismemberment Benefits are only applicable to Active participants and do not apply to Retired participants.

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SECTION VII

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Ulliance Life Advisor Employee Assistance Program is a program for participants and eligible dependents to assist with the many personal and work challenges you may encounter. Some areas of assistance include managing stress or depression, learning new parenting skills, or finding a nursing home for a loved one. Ulliance provides services to meet your needs, including short-term counseling, coaching, crisis intervention, and community resources.

Other examples of areas of assistance the Employee Assistance Program provides include:

- Relationship and family concerns
- Death of a loved one
- Stress, anxiety and depression
- Substance abuse
- Eldercare or childcare referrals
- Financial or legal referrals

The Ulliance Life Advisor Employee Assistance Program is confidential and available at no cost to Fund participants and eligible dependents. To learn about these services or to use them, including 24/7 crisis assistance, you may call (800) 448.8326 or visit www.lifeadvisor.com.

SECTION VIII

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and general limitations apply to all benefits provided by the Michigan State Painters Insurance Fund unless specifically waived by a particular benefit section.

Medical Necessity

Benefits under this Plan are payable only for services and supplies which are considered by the Trustees to be medically necessary in view of the patient's condition and diagnosis. For example, non-emergency hospital admission and confinement over a weekend will be presumed not medically necessary and not an eligible expense incurred. Hospital admission for surgery which is generally performed on an out-patient basis will not be considered eligible for benefits unless such admission is medically necessary due, for example, to a co-existent medical condition.

Work Related Disabilities and Expenses

Payment will not be made by the Plan for expenses incurred because of illness, disease, defect or injury which occurs during, or arises out of, any employment or other enterprise for pay or profit, or for which benefits are available under Workers' Compensation or other law covering expenses incurred from employment.

Reasonable and Customary Charges

Payment will not be made by this Plan for any expense incurred or charge made, which the Trustees determine is not reasonable or customary as defined herein.

Treatment Sponsored by Governmental Units

Payment *will not* be made by the Plan for expenses incurred:

1. While confined in a hospital owned or operated by the Federal Government or other government unit; or
2. For treatment by a physician employed by the Federal Government or other governmental unit; or
3. For services or supplies furnished by or at the request or direction of the Federal Government, any of its agencies, or other government unit unless the Eligible person is legally required to pay.

This exclusion will not prevent coordination of benefits with a plan specifically established by a governmental unit for its own civilian Employees and their dependents.

Treatment Without Charge

Payment will not be made for confinement in any hospital or treatment by a physician when the hospital or physician makes no charge that the Eligible Person is legally required to pay or would not be charged in the absence of these benefits.

Experimental Treatment Procedures

Benefits under this Plan are for the treatment of accidental bodily injury or sickness by generally recognized medicines, surgery and other techniques or devices. Medicines, treatment techniques and devices which are not generally recognized by professional peer groups (such as the American Medical Association) or by regulatory governmental authorities (such as the Food and Drug Administration) will be considered experimental and will not be considered eligible expenses under this Plan. For the purposes of this provision, recognized treatment or medicines used in a non-routine manner (frequency or dosage) will be considered experimental.

Reimbursement of Medical Expenses

Under any provision of the Plan providing for reimbursement of expenses, the Plan will only pay for expenses defined as medical care expenses in Section 213(d) of the Internal Revenue Code.

General Exclusions and Limitations

This Plan *does not pay for expenses* caused by, incurred for or resulting from:

1. Declared or undeclared war, or any act thereof, or while in the military services of any country;
2. Services, treatment or supplies received from a dental or medical department maintained by a mutual benefit association of this or another employee benefit plan or labor union;
3. Services, treatment or supplies, which are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the cost;
4. Services or treatment rendered or supplies furnished primarily for cosmetic purposes, except as otherwise provided under the Plan pursuant to the Women's Health & Cancer Rights Act of 1998;
5. Services performed or supplies furnished by other than a physician;
6. Services, treatment or supplies rendered or furnished:

a. Before the individual concerned became an Eligible Person; or

b. Without the recommendation and approval of a legally qualified physician;

7. Services related to obesity, diet or weight control, including but not limited to: exercise programs, surgery, special diet or diet supplements, pre-natal vitamins, amphetamines, or any form of diet medication whether or not recommended or supervised by a physician, including dietary or nutritional counseling, books, pamphlets or classes;

8. Implantation within the human body of artificial mechanical devices designed to replace human organs other than pacemakers or similar such devices which merely assist rather than replace the function of the organ;

9. Services performed or supplies prescribed or furnished by other than a physician;

10. Growth hormones;

11. Reversal of tubal ligations, vasectomies or other sterilization procedures;

12. Special home construction to accommodate a disabled person;

13. Education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment beyond the first medically necessary visit. Special education or like services, regardless of the type of education, the purpose of the education, the recommendation of the attending physician or the qualification of the individual rendering the educational services;

14. Rest cures or custodial care;

15. Speech therapy, other than charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) while eligible in the Plan and as the result of a disease or accidental injury. Speech therapy to improve speech in the absence of disease or accidental injury (such as for a learning disability or speech delay) is considered special education and is not covered;

16. Supplies or equipment for personal hygiene, comfort or convenience;

17. Services, treatment or care rendered by a participant of the Eligible Participant's family;

18. Treatment or services for or in connection with financial counseling;

19. Treatment or services for primal therapy, rolfing, psychodrama, megavitamin therapy, bicenergetic therapy, vision perception training, or carbon dioxide therapy;

20 Cosmetic or reconstructive surgery which:

    a. is not necessary for the prompt repair of accidental bodily injury, sickness or disease which occurs while the patient is not eligible; and

    b. is not performed within two (2) years from the date of a covered loss.

21. Dietary or nutritional counseling, books, pamphlets or classes except for diabetes;

22. Charges incurred for travel, whether or not recommended by a physician.

23. Treatment of infertility, including artificial insemination, invitro fertilization, or embryo transfer process.

24. Expenses for which a third party may be liable through coordination of benefits, negligence, or other reason.

25. So-called heroic medical services, as determined by a panel of three consulting physicians appointed by the Plan, in connection with injury or illness that is either diagnosed as terminal for which life-sustaining procedures would serve to artificially delay death or resulting in an irreversible coma or persistent vegetative state.

26. Hospital confinement or treatment which starts before the effective date of eligibility.

27. Surcharge or non-resident tax levied by community hospitals.

28. Installation of air conditioning units, 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.

29. Medical treatment or services, if any, that are not recommended and approved or prescribed by a physician.

30. Payment of benefits relating to injuries sustained or incurred in a motorized vehicle accident, or any complications relating to such injury or accident, irrespective of cause. This exclusion is not limited to expenses related to automobiles and trucks covered by Michigan's no-fault law, but also applies to motorized vehicles not covered by the law such as motorcycles, boats, snowmobiles, riding lawnmowers, ATVs and other

recreational vehicles, along with other motorized vehicles not covered by the law.

31. Television, telephone, guest trays or other non-essential personal items and services including take-home prescription drugs and supplies.

32. Major Medical Benefit, any deductible required by the Basic Plan or for reimbursement of deductibles of either the Basic Plan Benefit or Major Medical Benefit Schedules.

33. Court ordered confinements and treatment required by court orders **even** when prescribed by a Physician.

34. Hospital confinement which is the result of an order of any Court of Law to any eligible Employee or his or her eligible dependents. Neither Basic nor Major Medical Benefits will be paid.

35. Injuries sustained while engaged in illegal activity.

Subrogation

If the Fund makes any payment or anticipates making any payment to a Covered Person or for the benefit of a Covered Person resulting from facts that give rise to a claim or cause of action against a third party, whether the Covered Person is or is not at fault, the Fund reserves the right, to the extent of such payment, to subrogation to recover the amounts paid or anticipated to be paid to or on behalf of the Covered Person. The Covered Person agrees to reimburse the Fund for 100% of any payments so made or anticipated, out of all monies recovered from the third party as a result of judgment, settlement or otherwise.

The Fund is subrogated to any and all rights of recovery and causes of action the Covered Person has against any third party. Third parties include spouses and other family members, and various forms of insurance coverage (such as uninsured, underinsured, no-fault, worker's compensation, medical payments, personal injury protection and others) for either the Covered Person or the person responsible for the Covered Person's condition causing the Fund's payments or anticipated payments.

The Covered Person agrees to furnish information and assistance to the Fund, and to execute and deliver all necessary documents that the Fund's Administrator requests to facilitate the enforcement of the Fund's rights, including an Assignment and Acknowledgment of Lien for Benefit of the Michigan State Painters Insurance Fund.

In order to conserve the assets of the Michigan State Painters Insurance Fund for the benefit of Covered Persons, the Fund does not provide benefits for which a third party pays or maintains potential liability, including liability under personal injury or worker's compensation law. A third party means any person, insurer, employer or other person or entity maintaining liability for expenses paid to or on behalf of a Covered Person.

Consequently, the Fund is not required to pay for claims (past, present or future) by a Covered Person related to injury, sickness or illness caused by or claimed to be caused by a third-party or claims (past, present or future) related to an injury, sickness or illness for which a settlement, judgment, or any payment is received unless the Fund agrees to pay such claims pursuant to a written subrogation and reimbursement agreement. The Fund will have priority to recover any payments made or anticipated to be made if the Covered Person has been compensated by a third party for an injury, sickness or illness for which such payments are made.

If the Trustees of the Fund incur expenses to provide such benefits, a lien on recovery from a third party arises in favor of the Fund. Such recovery from a third party shall constitute an asset of the Fund, and the Fund maintains an equitable lien and constructive trust on a Covered Person's recovery from a third party resulting in a medical condition for which the Fund incurred expenses, up to the amount of expenses the Fund incurred.

Any claim, demand, action or right to recovery against a third party on the part of the Covered Person on whose behalf such benefit payments were made shall be subrogated to the Fund (whether or not the Fund intervenes in such action against the third party or otherwise pursues recovery), to the extent of the Fund's expenses. Any recovery against a third party shall be assigned to the Fund, regardless of whether the Covered Person executes an assignment or other acknowledgment of the superiority of the Fund's lien. The full amount of any recovery shall be subrogated and assigned, regardless of how the recovery is allocated, whether for emotional distress, loss of consortium for a Covered Person's spouse, wages, medical payments, attorney's fees, costs, interest or other designation, and irrespective of whether the Covered Person is made whole or third party liability is admitted or established.

The lien on a Covered Person's recovery applies to 100% of any recovery obtained by or on behalf of a Covered Person, including money paid to a dependent, parent, spouse, trust, attorney or other person receiving a recovery or, if deceased, any person who succeeds to a Covered Person's right of recovery, including the deceased Covered Person's estate, personal representative, executor, guardian, next friend, heir or other successor in interest of a deceased Covered Person, and shall not be reduced by attorney fees or costs that the Covered Person or the Covered Person's successor shall pay. The Fund's recovery will not be reduced if the Covered Person does not receive full compensation for his or her loss, as the make-whole doctrine is not applicable to the Fund.

If a Covered Person elects to pursue any claim against a third party for recovery of damages on a claim partially or wholly paid by the Fund, the Covered Person shall promptly notify the Trustees of the Fund in writing of the date the claim was filed, the forum in which it was filed and the name of every defendant and respondent, and execute all acknowledgements of liens, subrogation and reimbursement agreements and other documents requested by the Trustees. In addition, the Covered Person will cooperate fully with the Fund and not act in a manner that impairs the Fund in its efforts to assert its lien interest. The Covered Person will keep the Fund informed of the status of any legal action. Any violation by a Covered Person of his or her obligations to the Fund shall subject the Covered Person to liability for money not collected by the Fund, as well as the Fund's attorney's fees, costs and interest at 12% annually. The Fund may deny eligibility for benefits to the Covered Person and his or her dependents or deduct hours from an Employee's Hour Bank until the lien is satisfied in full. Money not paid to the Fund as a result of a Covered Person's violation of his or her obligations to the Fund constitute Fund assets and the Covered Person and any attorney of the Covered Person who participated in the violation will be deemed fiduciaries with respect to Fund assets.

Lien on Participant's Recovery

In order to conserve the assets of the Fund for the benefit of Covered Persons, the Fund does not provide benefits for which a third party pays or maintains potential liability, including liability under personal injury or Workers' Compensation law. The Trustees of the Fund may, in their discretion or inadvertently, provide such benefits, at which point a lien on recovery from a third party arises in favor of the Fund. Any claim, demand, action or right to recovery

against a third party on the part of the participant on whose behalf such benefit payments were made shall be subrogated to the Fund (whether or not the Fund intervenes in such action against the third party or otherwise pursues recovery), to the extent of the Fund's expenses, and any recovery against a third party shall be assigned to the Fund, regardless of whether the participant executes an assignment or other acknowledgment of the superiority of the Fund's lien, and regardless of how any recovery is allocated, whether for emotional distress, loss of consortium for a participant's spouse, wages, medical payments, attorney's fees, costs, interest or other designation, and irrespective of whether the participant is made whole or third party liability is admitted or established. The lien on a participant's recovery applies to 100% of any recovery obtained by a participant or, if deceased, any person who succeeds to a participant's right of recovery, including the deceased participant's estate, personal representative, guardian, next friend, heir or other successor in interest of a deceased participant, and shall not be reduced by attorney fees or costs which the participant or the participant's successor shall pay.

In the event a participant elects to pursue a claim against a third party for recovery of damages on a claim partially or wholly paid by the Fund, the participant shall notify the Trustees of the Fund in writing of the date the claim(s) was filed, the forum(s) in which it was filed and the name of the defendant(s) or respondent(s) and execute all acknowledgements of liens, subrogation agreements or other documents requested by the Trustees. In addition, the participant will cooperate fully with the Fund in its efforts to assert its lien interest. The participant will keep the Fund informed of the status of any legal action. Any violation by a participant of his or her obligations to the Fund shall subject the participant to liability for money not collected by the Fund, including the Fund denying eligibility for benefits to the participant and his or her family until the lien is satisfied in full.

Assignment of Payments

Since the Plan does not pay benefits resulting from accidental bodily injury or a sickness arising out of or in the course of employment, Covered Persons assign to the Fund all payments under the Michigan Workers' Disability Compensation Act, and workers' compensation laws of other states, up to the amount of money paid by the Fund if the Fund incurs any expenses arising out of or in the course of employment of a Covered Person, including attorney's fees and costs that the Fund incurs. Such assignments constitute valid assignments under Section 821(2) of the Michigan Workers' Disability Compensation Act.

Prohibition of Assignments of Rights to Receive Payments

The Fund is authorized to make payments directly to providers who perform services for Covered Persons. However, a Covered Person may not assign his or her right to receive payment to anyone else, including a health care provider, or authorize someone else, including a health care provider, to receive payment for a Covered Person. Consequently, any assignment that a Covered Person provides, including to a health care provider, is null and void.

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SECTION IX

GENERAL PLAN PROVISIONS

CIRCUMSTANCES THAT MAY RESULT IN LOSS OF ELIGIBILITY OF BENEFITS

Throughout this booklet the Trustees have tried to bring to your attention those circumstances, which might lead to a loss of eligibility and to describe any limitations, exclusions, or restrictions applicable to specified benefits.

The Trustees urge you to familiarize yourself with this information, especially as it relates to the requirements, which must be met in order to maintain your eligibility for benefits.

PARTICIPANT: You must work the required number of hours or make timely self-payments in order to maintain your eligibility.

If at any time you are uncertain about how a specific circumstance might affect your eligibility or benefit coverage, please contact the Fund Office and, if possible, try to do so before any circumstance arises.

CLAIMS REVIEW AND APPEAL PROCEDURES

Claim Review and Appeal

If you are not satisfied with the action taken on your claim, you have the right to obtain a review and an appeal. The procedures for review and appeal are set forth below.

The Trustees have full discretionary authority to determine eligibility for benefits under the Plan and to interpret the Plan, all Plan documents, Plan rules, and Plan procedures, and the terms of the Trust Agreement. Their decisions and interpretations will be given the maximum deference permitted by law for the exercise of such full discretionary authority and will be binding upon all persons involved.

Your Right to Request Review of an Adverse Benefit Determination

Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved through a phone call to one of the BCBSM Customer Service Representatives. You can locate the phone number in the top right-hand corner of the first page of your BCBSM Explanation of Benefits statement or in the letter we send to notify you that we have not approved a request for benefits.
In addition, the Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations 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 payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in your employer's health plan. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

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

"Urgent care claim" means a claim for medical care or treatment where 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, we will treat it as such. Absent a determination by your physician, we will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

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

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim. These reviews are level 1 reviews. If you disagree with a decision on your level 1 review, you maintain a right to appeal under procedures described below.

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 the Plan's internal review and appeals procedures before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

Review Procedure

A. Review Procedure – Post-service claims

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

review at each level. However, that 30-day timeframe may be suspended if BCBSM has not received information they have requested in writing from you or from your health care provider, for example your doctor or hospital.

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

1. To initiate review level 1 review, you or your authorized representative must send BCBSM a written statement explaining why you disagree with the 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 are provided with the 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 30 days, unless it has notified you in writing that it needs additional information to complete the review. If you agree with the response, it becomes BCBSM's final determination and the review ends.
2. If you disagree with the BCBSM response to your request for review at level 1, you may then proceed to appeal the decision. You must submit your appeal in writing under procedures set forth in the Appeals and Procedures For Appeals sections below.

B. Review Procedure – Pre-service claims

1. The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that BCBSM will provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. A determination will be issued within 15 calendar days of receipt of your request for a level 1 review.
2. If you disagree with the final BCBSM determination, or if the determination at each level is not issued within the 15 day time frame or the review procedures for level 1 are otherwise not complied with, you have the right to appeal the decision in writing under practices set forth in the Appeals and Procedures For Appeals sections below.

C. Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call: (313) 225-6800.

2. BCBSM will 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 the BCBSM decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, email, or other available similarly expeditious method. If the BCBSM decision is communicated orally, it must provide you or your authorized representative with written confirmation of its decision within two business days.

3. If you disagree with the BCBSM final determination or if it fails to issue the determination within 72 hours, or otherwise fails to comply with the review procedures, you have the option to appeal the decision in writing under practices set forth in the Appeals and Procedures For Appeals sections below.

APPEALS

If you receive an adverse benefit determination, you have 180 days following receipt of the notification to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you so request, you will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to the claim.

The period of time that a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record or other information shall be considered relevant to a claim if it:

1. was relied upon in making the benefit determination;
2. was submitted, considered or generated in the course of making the benefit determination without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all eligible Employees or dependents; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by fiduciaries of the Fund who are neither any individual who made the adverse determination nor a subordinate of such individual.

PROCEDURES FOR APPEALS

The Board of Trustees of the Fund has established procedures for reviewing appealed claims. If you disagree with the decision or actions taken on your claim, you or your authorized representative may do the following:

1. Appeal any denial of a claim for benefits by filing a written request.

2. Attach any information you have that you believe will enable the Board of Trustees to arrive at a favorable decision on your claim.

3 Review pertinent documents.

4. Return the completed appeal and any additional information you are submitting to the Board of Trustees, Michigan State Painters Insurance Fund, 6525 Centurion Drive, Lansing, Michigan 48917.

IMPORTANT: Your claim appeal to the Board of Trustees (called an "internal appeal") must be received in writing at the Fund Office within 180 days of the date that you were provided with notice of the claim denial, as a condition of consideration of the appeal.

The Board of Trustees will review all of the material submitted with your claim, the additional information you have furnished and the reasons why you believe that your claim should be paid. In addition, the Board will review all of the action taken by BCBSM and the Fund Office. After the Trustees have arrived at their decision, you will be promptly informed in writing of their decision, which shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based. You maintain the burden to establish that a Plan provision supports your claim or that a Plan exclusion does not apply to your claim. All decisions by the Trustees are final and binding.

If your internal appeal has been received by the Trustees at least 30 days before their next scheduled meeting, a decision on your appeal will normally be made at the next meeting. If an appeal is not received by the Trustees at least 30 days before the next scheduled meeting, the decision on your appeal may be delayed to the following scheduled meeting.

If special circumstances require additional time for the Board of Trustees to arrive at a decision on your internal appeal, the decision will be made by the third meeting of the Board of Trustees following receipt of your appeal and you will be informed of the special circumstances and the date the decision on your appeal will be made.

After the Board of Trustees makes a decision on your internal appeal, you will be provided with written notice of the decision not later than five days after the appeal decision is made.

Only an eligible Employee, Retiree or other person entitled to benefits or such person's dependent may submit an appeal or file a lawsuit relating to denial of a claim. The right to appeal or file suit cannot be assigned to any other person, including a health care provider.

You may file a lawsuit seeking a remedy for denial of your internal appeal. **However, no legal action may be commenced relating to a claim more than one year after the Board of Trustees' decision on your appeal or, if applicable, a decision on your external review of an appeal denial or an expedited external review.** Failure to appeal denial of a claim also bars the right to file suit relating to the claim. If your claim is paid after an appeal is granted by the Trustees or an external reviewer, or a court rules in your favor, the Fund will not pay any interest or compensatory or other damages resulting from delay in payment.

In addition to the internal appeal procedure described above, the Fund has implemented an external review process, which is available as an additional level of review after denial of an internal appeal. You or a representative whom you appoint who knows about your medical condition have an option to seek an external review of an adverse decision of the Board of Trustees on your appeal for any appeal denial that involves medical judgment where you or your provider may disagree with the Trustees' decision, any appeal denial that involves a determination that a treatment is experimental or investigational, or any appeal denial involving cancellation of coverage based on the Fund's determination that you gave false or incomplete information when you applied for coverage. You must file a written request for an external review within four months after the date you receive notice of an appeal denial, or the first day of the fifth month following your receipt of the appeal denial if there is no corresponding date four months after receipt of such notice. The external reviewer will either uphold the decision on your appeal or decide in your favor. The external reviewer will send you a written notice of the final external review decision. The decision of the external reviewer is final and binding. Any required provisions for external reviews specified above will comport with applicable law contained in the regulation at 45 C.F.R. § 147.136(d)(2), which the Fund elects to use.

If your initial claim for benefits has been denied and in the time for an internal appeal your life or health or your ability to regain maximum function is in serious jeopardy, you may seek an expedited internal appeal by the Board of Trustees and, if your claim involves a question of medical judgment, experimental or investigational treatment, or a retroactive cancellation of coverage referenced above as subjects of denials for which external reviews are available, you

may also seek an expedited external review of the decision, simultaneously with your appeal to the Board of Trustees. To file a request for an expedited appeal to the Board of Trustees, follow the procedures set forth above for internal appeals and note the expedited nature of the appeal. To file a request for an expedited external review, follow the procedures set forth above for external reviews and note the expedited nature of the request for review.

Disability Benefit Claims

The following rules apply to the processing of denials of disability benefit claims and appeals:

1. Benefit denial notices must contain:

    a. A complete discussion of 1) why the Fund denied the claim and the standards used in making the decision, including internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim, or a statement that none were used, and 2) if applicable, the basis for not following the views of health care professionals or experts who treated or evaluated the participant, or a disability determination made by the Social Security Administration.

    b. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to the claim.

    c. Notice that an appeal must be received in writing at the Fund office within 180 days of the date that the participant received notice of the claim denial as a condition of consideration of an appeal, with information on the procedure to submit an appeal.

2. Notices of denial of an appeal must contain:

    a. A complete discussion of 1) why the Fund denied the claim and the standards used in making the decision, including specific internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim, or a statement that none were used, and 2) if applicable, the basis for not following the views of health care professionals or experts who treated or evaluated the participant, or a disability determination made by the Social Security Administration.

    b. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to the claim.

c. Notice of the participant's right to file a lawsuit under Section 502(a) of ERISA over denial of the appeal.

d. Notice that no legal action may be commenced relating to denial of the appeal more than one year after the Board of Trustees' decision on the appeal, with insertion of the calendar date of one year from the date of the meeting at which the Board made the decision on the appeal as a deadline to file suit.

3. The Fund will notify the participant of a claim denial within 45 days after the Fund receives the claim. This period may be extended if necessary pursuant to procedures in 29 C.F.R. § 2560.503-1(f)(3). The Fund will notify the participant of an appeal denial within five days after the Board of Trustees' decision on the appeal.

4. The Fund may not deny an appeal based on any new or additional evidence or rationale that was not considered in the initial denial unless the participant is given notice of such evidence or rationale and a reasonable opportunity to respond before the Fund's appeal decision becomes final.

5. The Fund will ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of any person involved in the claims or appeals process.

6. If a participant's address is in a county where at least 10% of the population is literate only in the same non-English language as the participant, benefit denial notices will be provided in the non-English language and the Fund will follow other procedures set forth in the Affordable Care Act.

HOW BENEFITS ARE REDUCED

Coordination of Benefits With Other Group Plans

To alleviate the problem of excess coverage, which needlessly increases the costs of protection, all the Plan benefits will be coordinated with the following coverage:

1. Individual, group, blanket, franchise, general liability, common carrier insurance coverage; or

2. Hospital or medical service organizations, group practice, and other prepayment coverage; or

3. Any coverage under any labor-management trust funds, union welfare plans, employer organization plans or Employee benefit organization plans; or

4. Any coverage under governmental programs or any coverage required or provided by any statute.

Benefits will be reduced under certain circumstances when an individual is covered under this Plan and under one or more other plans, but it is intended that the individual will be fully reimbursed for allowable expenses under the various plans to the extent combined benefits equal 100% of the total allowable expenses.

Benefit Determination

As stated above, the Plan will coordinate benefits with all group programs providing coverage to the Employee or his or her dependents for all claims.

1. When the other group plan does not have a provision for Coordination of Benefits, it must be considered the primary carrier and must make benefit payment first before this Fund will consider payment.
2. When the other group plan does have a provision for Coordination of Benefits, the order of benefit payments will be determined as follows:

The eligible person must claim benefits due from the "primary" plan determined by these rules for its share of eligible expenses, including benefits or services available from prepayment coverage programs such as Health Maintenance Organizations. When this Plan is "secondary" according to the established order of benefit determination, the term "benefits payable under another Plan" will include the benefits that would have been paid if the eligible person made a proper claim on that Plan or used its services. This Plan's liability and its benefit payments will not increase simply because the eligible person elects not to use the "primary" coverage.

Claim for a Covered Employee

The covered Employee must first submit all charges to the group with the earliest effective date. After the charges have been considered, copies of all charges and payment statements should then be submitted to the secondary plan for consideration.

When Claim is on the Dependent Spouse

1. The other plan (the plan covering the spouse as Employee) will, without exception, pay benefits first when the claim is on the spouse.
2. This Plan (which covers the spouse as a dependent) will pay second and will coordinate with the other plan.

When Claim is for a Dependent Child

The Trustees have adopted the coordination provision known as the birthday rule. The birthday rule provides that:

In claims involving children, the order of benefit payments will be as follows:

1. The plan covering the parent whose birthday occurs earliest in the calendar year will pay first.
2. The plan covering the parent whose birthday occurs later in the calendar year, and having a provision for Coordination of Benefits, will pay second.

Special Note: If an Employee covered under this Plan has two types of group coverage, the plan with the earliest effective date must pay first. The Plan covering the Employee for the shortest period of time will consider the balance due upon receipt of:

1. A copy of itemized bills; and
2. A copy of the payment statement.

If there is a divorce and/or remarriage, the financial and medical responsibility is generally stipulated by court decree. If the decree does not stipulate the responsibility, or if one of the parents has remarried, there are special rules applied. Participants are required to submit legal documents that are requested by the Fund Office so that the order of benefit determination can be established. Contact the Fund Office for further information.

Coordination of Benefits with Medicare

When you or your Dependent becomes eligible for Medicare (officially known as Title XVII of the Social Security Amendments of 1954, amended effective July 1, 1973, and as thereafter may be amended) in addition to this Plan, the Trustees require that you enroll in Medicare. This applies whether you are eligible due to attained age or to a qualifying disability.

Effect on Benefits

When a person is eligible in this Plan and in Medicare, Medicare generally is required to pay first. Benefits payable by this Plan may be reduced by the amount Medicare pays, but only if the total of this Plan's normal benefits and Medicare's payment will be more than 100% of eligible expenses.

You or your Dependent will be considered to be currently eligible and covered by Medicare as soon as you would be eligible to enroll whether or not you actually enroll as you should.

Limitations

To comply with Federal regulations, the provision will not apply to an Employee who is still eligible in this Plan due to Employer contributions or to the spouse of such an Employee.

Medicare will always be required to pay first when eligible expenses are incurred by:

1. Persons eligible due to self-payments of contributions to this Plan; or
2. Retired Employees and their Dependents; or
3. Employees eligible for Medicare on the basis of permanent kidney failure, after the first 18 months of treatment.

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SECTION X

STATEMENT OF PARTICIPANT'S RIGHTS

Information Required by the Employee Retirement Income Security Act (ERISA)

Introduction

You have probably heard about ERISA. ERISA stands for the Employee Retirement Income Security Act, which was signed into law in 1974, and which has been amended since that time.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the Plan administered by the Michigan State Painters Insurance Fund. The Trustees of your Fund, in consultation with their professional advisors, have reviewed these standards carefully and have taken the steps necessary to assure full compliance with ERISA.

ERISA requires that Plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits, and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this Summary Plan Description.

ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan. This information follows:

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

Statement of Participant's Rights Under ERISA

As a participant in the benefits plan administered by the Michigan State Painters 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 Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another 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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator, which is the Board of Trustees, by writing to: Michigan State Painters Insurance Fund, 6525 Centurion Drive, Lansing, Michigan, 48917-9275 or telephone the Fund Office at (517) 321-7502. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC, 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.

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Participants will be notified of any Plan changes within the time prescribed by applicable law.

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SECTION XI

OTHER IMPORTANT INFORMATION

The Trustees Interpret the Plan

Under the Trust Agreement creating the Fund, and the terms of this Plan, the Board of Trustees have the sole authority to make all decisions relating to the Plan, including final determinations regarding any application for benefits and the interpretation of the Plan and any administrative rules adopted by the Trustees. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Trust, and the Plan provides, that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Any interpretation of the Plan's provisions rests with the Board of Trustees. No employer or union, any representative of any employer or union, or any individual Trustee or other Plan representative, is authorized to interpret this Plan on behalf of the Board nor can an employer, union, or any individual Trustee or other Plan representative act as an agent of the Board of Trustees.

The Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from participants regarding eligibility rules, benefits, and claims procedures, But, if there are any questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a determination.

The Plan Can be Changed

The Trustees have the legal right to change the Plan.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To do so may require Plan changes from time to time.

Changes in the Plan may also be required in order to preserve the Fund's tax-exempt status under Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, the Trustees may find it necessary to change Plan provisions so that the Trust does not lose its tax-exempt status.

The Plan is Tax-Exempt

The Fund is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the employers' contributions to the Fund are tax deductible and are not included as part of

your income. Consequently, in most cases the benefits paid on your behalf are not taxable as personal income. Also, investment earnings on Fund assets are excluded as taxable income of the Fund since they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption works to the benefit of both employer and Employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Fund qualified as a tax-exempt trust under the Internal Revenue Code.

Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of this Plan, the Fund may, without consent or notice to any covered person, release to or obtain from any insurance company or other organization or individual, any information, with respect to any covered person, which the Fund deems to be necessary for such purposes. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Excess Payments and False Claims

Whenever payments have been made by the Fund for expenses in excess of the amount allowed under the Plan, the participant shall repay the Fund the amount of the payment. If the participant fails to make such repayment promptly on request, the Fund may deny eligibility for benefits to the participant and his or her dependents until the payment is reimbursed in full, along with interest at the rate described below and the Fund's attorney's fees and costs.

If a person receives a benefit from the Plan that the person knows or should have known he or she is not entitled to receive, or through action or inaction that enables a claim for benefits to be presented that contains a false statement or which is for a person ineligible for benefits, the person shall maintain responsibility to reimburse the Fund for the full amount of any benefit paid plus interest at the rate of 12% from the date of any payment made by the Fund, plus all attorney's fees and costs incurred by the Fund in connection with such wrongfully paid benefits, in addition to applicable criminal or civil penalties, and the Fund may deny eligibility for benefits to the person and his or her dependents, or deduct hours from an Employee's hour bank, until the liability is satisfied in full, in addition to pursuing legal action to pursue the right to reimbursement. Improperly received benefits are Fund assets and persons who receive them are fiduciaries of the Fund to the extent that they receive such benefits.

Recission of Coverage

The Fund may retroactively terminate coverage under the Plan of a person receiving benefits if a participant or dependent engages in fraud or makes an intentional misrepresentation or omission of a material fact relating to such person's benefits under the Plan. The Fund may retroactively terminate coverage under the Plan of a person receiving benefits if a participant or dependent engages in fraud or makes an intentional misrepresentation or omission of material fact relating to such person's benefits under the Plan.

Recovery of Overpayments

If it is determined that any benefit paid to a participant or dependent of a participant should not have been paid, the participant shall repay the Fund the amount of the overpayment without limitations. Overpayments are Fund assets and persons who receive the benefits of overpayments are fiduciaries of the Fund to the extent that they benefit from any overpayment. If the participant fails to make such repayment of a wrongfully made payment promptly on request, the Fund may deny eligibility for benefits or reduce benefit payments to the participant and his or her dependents, and deduct hours from an Employee's Hour Bank, until the overpayment and any expenses incurred by the Fund, including legal fees and costs, liability for which the participant maintains responsibility, are reimbursed in full. The Fund may also pursue legal action against the participant and any person who benefited from the overpayments and recover the overpayment and all attorney's fees and costs incurred by the Fund for which such overpayment recipient shall be liable.

Cooperation in Administration of Claims

All participants and dependents of participants maintain an obligation to cooperate with the Fund Office in administering claims. This cooperation may include providing information the Fund requests, undergoing medical examinations by physicians selected by the Trustees, participating in case management to the satisfaction of the Trustees, and otherwise assisting the Fund in any matter relating to a claim, as a condition of receiving Plan benefits.

Name of the Plan

The Plan is the Michigan State Painters Insurance Fund.

Type of Plan

This Plan is a welfare benefit plan that provides Health Care Benefits for expenses due to hospitalization, surgery and medical treatment. This Plan also provides benefits for Death, Accidental Dismemberment and Weekly Accident and Sickness (Loss of Time), and other benefits described in the Plan.

Plan Administration

The Plan is administered and maintained by the Board of Trustees. The Trustees have selected a professional employee benefits administrative firm as the Administrative Manager of the Plan. The Administrative Manager is responsible for carrying out the Trustees' policy decisions, recordkeeping, accounting and coordinating payment of most benefits subject to the Plan Documents. The address and telephone numbers of the Plan and the Fund Office are the same as those of the Administrative Manager.

Name and Address of Administrative Manager

The Administrative Manager selected by the Trustees is:

TIC International Corporation
6525 Centurion Drive
Lansing, Michigan 48917
Telephone: (517) 321-7502
Fax: (517) 321-7508
Toll Free: (800) 482-0948

Name and Address of Claims Processor

Blue Cross Blue Shield of Michigan
Jacqueline Nakfoor
Account Manager, KLGB-Trust Funds
232 S. Capital Avenue
Mail Code: L08A
Lansing, Michigan 48933
Telephone: (517) 325-4587
Fax: (877) 570-9658

Name and Title of Each Trustee

The Trustees of this Fund, who can be reached through the Fund Office, are:

Management Trustees

Chad Christensen
Niles Industrial Coatings
201 S. Alloy Drive
Fenton, Michigan 48430

Dominic Logeonelo
R & L Painting LLC
10220 West Herbison Rd.
Eagle, Michigan 48822

Harlow Murray
Murray Painting
6058 Hackett Road
Freeland, Michigan 48623

Gary Niles
2138 Sycamore Circle
Burton, Michigan 48509

Thomas Niles
Niles Construction Services
5048 Pilgrim Drive
Flint, Michigan 48507

David Perez
5430 Frovan Place
Saginaw, Michigan 48638

Union Trustees

Travis Cary
Painters Local 1011
116 South 9th Street
Escanaba, Michigan 49829

Jake Fluty
Painters Local 1052
3115 Joyce Street
Burton, Michigan 48529

Fred Frederickson
Painters Local 845
419 S. Washington Square
Suite 102
Lansing, Michigan 48933

Robert Gonzalez
Painters District Council 1M
14587 Barber Avenue
Warren, Michigan 48088

Joshua Ovalle
Painters District Council 1M
7677 Midland Road
Freeland, Michigan 48623

Tim Schwerin
Painters District Council 1M
1473 North 30th Street
Galesburg, Michigan 49053

Parties to the Collective Bargaining Agreement

The Fund is established and maintained under the terms of collective bargaining agreements between Local Unions participating in the Fund and Employers in their areas. The agreements set forth the conditions under which participating Employers are required to contribute to the Fund.

The parties to the collective bargaining agreements are International Union of Painters and Allied Trades, Local Unions 312, 845, 1011, 1052 and 1803, and those Employers that execute collective bargaining or other written agreements with the Local Unions. Upon written request to the Fund Office, Participants and Beneficiaries may obtain a complete list of Employers and Local Unions sponsoring the Plan and information whether a particular Employer or Local Union is a sponsor of the Plan, and if so, the address of a particular Employer or Local Union, and copies of applicable collective bargaining agreements, which may also be inspected at the Fund Office.

Internal Revenue Service
Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Fund is 23-7319169. The Plan Number is 501.

Legal Counsel and Agent for Service of Legal Process

Jeffrey M. Lesser
30300 Northwestern Hwy., Suite 320
Farmington Hills, Michigan 48334
(248) 785-5225

Service of legal process may also be made upon any Fund Trustee.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules in the Eligibility Section of this Document. Circumstances which may cause you to lose eligibility are explained in the Eligibility Rules in the Eligibility Section of this Document.

Sources of Fund Income

Sources of Fund income include Employer contributions, Employee self-payments and investment earnings. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the Local Unions and those Employers that execute collective bargaining agreements with the Local Unions.

The agreements each specify the amount of contributions, due date of contributions, type of work for which contributions are payable and the geographic area covered by the agreements.

Method of Funding Benefits

Benefits payable under this Plan are self-funded and paid directly from the accumulated assets of the Fund, except that death benefits, accidental death and dismemberment benefits, and stop loss coverage are provided through contracts with insurers. A portion of Fund Assets are also allocated for reserves to meet future liabilities and to carry out the objectives of the Fund.

Fiscal Year of the Plan

The financial records of this Plan are based on a Plan year which begins September 1 and ends August 31.

The Plan May be Terminated

The Plan may be terminated by resolution of the Fund's Board of Trustees if they deem such action desirable and in the best interests of the Plan's participants and beneficiaries.

In the event of termination of the Plan, the Trustees shall use the Fund's assets to satisfy its obligations and distribute any remaining surplus in the manner that will, in their opinion, best effectuate the purpose of the Plan consistent with applicable law, and take other steps to wind down the Plan.

DELTA DENTAL®

APPENDIX

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 1655-0001, 0002, 0003, 0004, 0005, 0006, 0007, 0008, 0009, 0011, 0012, 0013
Michigan State Painters Insurance Fund

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	**100%**	**100%**	**100%**
Emergency Palliative Treatment – to temporarily relieve pain	**100%**	**100%**	**100%**
Sealants – to prevent decay of permanent teeth	**100%**	**100%**	**100%**
Brush Biopsy – to detect oral cancer	**100%**	**100%**	**100%**
Radiographs – X-rays	**100%**	**100%**	**100%**
Basic Services			
Minor Restorative Services – fillings and crown repair	**80%**	**50%**	**50%**
Endodontic Services – root canals	**80%**	**50%**	**50%**
Periodontic Services – to treat gum disease	**80%**	**50%**	**50%**
Oral Surgery Services – extractions and dental surgery	**80%**	**50%**	**50%**
Other Basic Services – misc. services	**80%**	**50%**	**50%**
Relines and Repairs – to prosthetic appliances	**80%**	**50%**	**50%**
Major Services			
Major Restorative Services – crowns	**50%**	**50%**	**50%**
Prosthodontic Services – bridges, dentures, and crowns over implants	**50%**	**50%**	**50%**
Orthodontic Services			
Orthodontic Services – braces	**50%**	**50%**	**50%**
Orthodontic Age Limit –	**through age 19 and under**	**through age 19 and under**	**through age 19 and under**

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Benefits for space maintainers are unlimited for people age 17 and under.
- Bitewing X-rays are payable twice per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Two sealants are payable per calendar year for any tooth. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are not Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- Antibiotic drug injections are Covered Services. Occlusal guards are payable with no time limitations.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,500 per person total per Benefit Year on all services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered as defined by the Fund.

Eligible People – As defined by the Fund.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which the employee's eligibility terminates.

Also eligible are your legal spouse and your children to the end of the month in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled, if they meet criteria for eligibility in the plan and Summary Plan Description of the Fund.

Customer Service Toll-Free Number: 800-524-0149 (TTY users call 711)
https://www.DeltaDentalMI.com
Contract Start Date: January 1, 2022
Document Creation Date: April 27, 2022

Delta Dental PPO™
Our national PPO program

Welcome!

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan. Delta Dental of Michigan is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 800-524-0149 or access our website at www.DeltaDentalMI.com.

You can easily verify your own Benefit, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalMI.com and selecting the link for our Consumer Toolkit®. The Consumer Toolkit will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

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Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

I. Delta Dental PPO Certificate

Delta Dental Plan of Michigan, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Enrollee. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and the Contractor.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.

Goran M. Jurkovic, CPA, CGMA President and CEO
Delta Dental Plan of Michigan, Inc.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

The amount permitted under the applicable fee schedule for This Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year

The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year, unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and the Contractor.

Child(ren)

Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim

A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment

The percentage of the charge, if any, that you must pay for Covered Services.

Contractor

The employer, organization, group, or association sponsoring This Plan.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Member Plan

An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental Premier® Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that

Dentist's local Delta Dental Member Plan.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- Delta Dental PPO Dentist ("PPO Dentist") – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
- Delta Dental Premier Dentist ("Premier Dentist") – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
- Nonparticipating Dentist – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.
- Out-of-Country Dentist – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Delta Dental Premier Dentists are sometimes collectively referred to herein as "Participating Dentists." Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Delta Dental Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as "Non-PPO Dentists."

Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dependent(s)

Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits

Enrollee

You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Maximum Approved Fee

The Maximum Approved Fee is the lowest of:

- The Submitted Amount
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Member(s)

Any Enrollee or Dependent with coverage under This Plan.

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period

The period of time, as determined by the Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate

A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre- Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any

additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Special Enrollment Period

A period outside of the Open Enrollment Period in which you or your Dependent can obtain coverage under This Plan due to a qualifying life event.

Spouse

Your legal spouse.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Members pursuant to this Certificate and your Summary of Dental Plan Benefits.

III. Enrolling in This Plan

The Open Enrollment Period, if applicable, will be established by the Contractor and will occur on an annual basis. During the Open Enrollment Period, all eligible persons as defined in your Summary of Dental Plan Benefits may enroll in This Plan. You and/or your Dependents may not enroll in This Plan at any other time during the applicable Benefit Year except in the following instances:

a. Newly hired or rehired employees (if applicable): You will be eligible to enroll on the date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Dental Plan Benefits.
b. New Spouse: Your new Spouse will be eligible to enroll on the date of marriage.
c. Newborn: Your newborn will be eligible to enroll on the date of birth.
d. Legal adoptions or guardianships: Your newly adopted Child(ren) and/or the minor Child(ren) that you and/or your Spouse have guardianship over will be eligible to enroll on the date that the legal petition for adoption or guardianship becomes legally final, or the date on which the Child(ren) begins residing with the Enrollee and the Enrollee assumes responsibility for the Child(ren) while waiting for adoption or guardianship to become final.
e. New Stepchild: Your new stepchild will be eligible to enroll on the date that the Child's natural parent becomes a Dependent.
f. To the extent Contractor permits Dependents other than those defined in this Certificate to enroll in This Plan, such Dependents will be eligible to enroll on the date that they become an eligible Dependent. Any such additional Dependents permitted by Contractor shall be set forth in your Summary of Dental Plan Benefits.
g. All others will be permitted on the date that Delta Dental approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Dependent.

IV. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.DeltaDentalMI.com or call 800-524-0149.

V. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at 800-524-0149.
3. After you receive your dental treatment, you or the dental office staff will file a Claim form, completing the information portion with:
   a. The Enrollee's full name and address
   b. The Enrollee's Member ID number
   c. The name and date of birth of the person receiving dental care
   d. The Contractor's name and number

Notice of Claim Forms

Delta Dental does not require special Claim forms. However, most dental offices have Claim forms available. Participating Dentists will fill out and submit your dental Claims for you.

Mail Claims and completed information requests to:

Delta Dental
P.O. Box 9085
Farmington Hills, Michigan 48333-9085

Pre-Treatment Estimate

A Pre-Treatment Estimate is not required to receive payment, but it allows Claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a Claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under This Plan are post-service Claims. All Claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a Claim is filed, Delta Dental will adjudicate it within 30 days of receiving it. If there is not enough information to adjudicate your Claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the Claim, and (d) inform you or your Dentist that the information must be received within 45 days or your Claim will be Denied if the services were performed by a Nonparticipating Dentist, or not chargeable to the Member if the services were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to adjudicate your Claim. If you or your Dentist does not supply the requested information, Delta Dental will deny your Claim. In such case, you will be responsible for all charges if the services were performed by a Nonparticipating Dentist. If the services were performed by a Participating Dentist, the services will not be chargeable to the Member. Once Delta Dental adjudicates your Claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Contractor, call Delta Dental's Customer Service department, toll-free, at 800-524-0149, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333- 9089, to request a form to designate the person you wish to appoint as your representative. Delta Dental will only recognize the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to your Contractor or call Delta Dental's Customer Service department, toll-free, at 800-524-0149. You may also write to Delta Dental's Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing to Delta Dental, please include your name, the Contractor's name and number, the Enrollee's Member ID number, and your daytime telephone number.

VI. How Payment is Made

Delta Dental shall make payments for Covered Services in accordance with the type of plan selected by the Contractor. The type of plan selected will be identified on your Summary of Dental Plan Benefits.

Delta Dental PPO (Point-of-Service)

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the Nonparticipating Dentist Fee for Covered Services.

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Delta Dental PPO (Standard)

Regardless of your Dentist's participating status, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. If your Dentist is not a PPO Dentist, but is a Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full

payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Orthodontics

If This Plan includes orthodontics, it will be identified on and paid as reflected in your Summary of Dental Plan Benefits.

Covered Services Requiring Multiple Visits

In the event a Covered Service requires more than one (1) visit with your Dentist, payment for the Covered Service will be rendered upon Completion Date.

VII. Benefit Categories

The Benefits covered by This Plan are set forth in your Summary of Dental Plan Benefits.

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered under the terms of this Certificate.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract between Delta Dental and the Contractor.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments

of occlusal guards.

30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision abutments, attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
42. Myofunctional therapy.
43. Mounted case analyses.
44. Molecular, antigen or antibody testing for a public health related pathogen.
45. Any and all taxes applicable to the services.
46. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Caries risk assessment performed on a Member age 2 or under.
5. Local anesthesia.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy as an aid to the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of

inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.

26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
27. Full mouth debridement, when done on the same day as comprehensive evaluation.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
31. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
32. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
33. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
34. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
35. Capture only images which are not associated with any interpretation or reporting.
36. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
37. Implant removal when performed within three (3) months of an implant/mini-implant on the same tooth by the same dentist or dental office.
38. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
6. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age 8 and under.
10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restorations on the same tooth are also subject to this five-year limitation.
11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.
13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
14. Hard full or partial arch occlusal guards are payable once in a lifetime.
15. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over.
16. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural

tooth in a 36 month period.

17. Prosthodontic Services limitations:

    a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.

    b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.

    c. A removable unilateral partial denture is payable once per quadrant in any 5 year period unless the loss of additional teeth requires the construction of a new appliance.

    d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.

    e. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.

    f. Implant removal is payable once per lifetime per tooth or area.

    g. Implant maintenance is payable once per any twelve (12) month period.

    h. Removal of a broken implant retaining screw is payable once in a 5 year period.

18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:

    a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.

    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

    c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.

20. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.

21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.

22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

    Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

    a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.

    b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

    c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.

    d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

    e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.

    f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

    g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.

    h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.

23. Maximum Payment:

    a. All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.

24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible

amount is met.

25. Caries risk assessments are payable once in any 12-month period for Members age 3-18.
26. Assessments of salivary flow by measurement are payable once in any 36-month period.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
29. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five (5) applications per day.
30. Sealants are covered once per tooth per lifetime on first permanent molars for Members age 9 and under.
31. Sealants are covered once per tooth per lifetime on second permanent molars for Members age 14 and under.
32. One cone beam CT is allowed within a twelve (12) month period except when performed for TMD treatment.
33. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a twelve (12) month period when done by the same dentist/dental office.
16. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same dentist/dental office.
17. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

IX. Coordination of Benefits

Coordination of Benefits ("COB") applies to This Plan when a Member has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan's Benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your Claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the Member to This Plan's Enrollee, as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another plan that does not coordinate benefits, it will always be primary.

2. Enrollee v. Dependent Coverage

   The plan that covers the Member as an Enrollee will be primary over a plan that covers the Member as a dependent. However, please note that if the Member is a Medicare beneficiary, federal law may reverse this order.

3. Children (Parents Divorced or Separated)

   If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

   If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the Child's health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

   If neither of these rules applies, the order will be determined as follows:

   a. First, the plan of the parent with custody of the Child will be primary;

   b. Then, the plan of the spouse of the parent with custody of the Child will be primary;

   c. Next, the plan of the parent without custody of the Child will be primary; and

   d. Last, the plan of the spouse of the parent without custody of the Child will be primary.

4. Children and the Birthday Rule

   The plan of the parent whose birthday is earliest in the calendar year is always primary for Children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Laid Off or Retired Employees

   The plan that covers the Member as a laid off or retired employee or as a dependent of a laid off or retired employee will be primary.

6. COBRA Coverage

   The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA) will be primary.

7. Other Plans

   If none of the rules above determines the order of benefits, the plan that has covered the Member for the longer period will be primary.

   If the other plan does not have rule 5 and/or rule 6 (above) and decides the order of benefits differently from This Plan, This Plan may ignore either of those rules.

   In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures for determining which plan is primary, unless prohibited by applicable law.

   How Delta Dental Pays as Primary Plan

   When Delta Dental is the primary plan, it will pay for Covered Services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan.
When Benefits are reduced as described above, each Benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person regarding the Claim being coordinated. Delta Dental need not tell or get the consent of any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to pay the Claim.
Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made the payment.

That amount will then be treated as though it were a Benefit paid under This Plan, and Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, Delta Dental may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Member.

Payment includes the reasonable cash value of any benefits provided in the form of services.

X. Reconsideration and Claims Appeal Procedure

Reconsideration

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Enrollee's Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure. This notice will also advise you of your right to an external review with the Department of Insurance and Financial Services ("DIFS") under the Patient's Right to Independent Review Act ("PRIRA").

Pursuant to PRIRA, you or your authorized representative have the right to request an external review of an Adverse Benefit Determination. You are only eligible for the external review process if you have completed the internal formal claims appeal procedure, or if Delta Dental fails to complete the internal process within the allowable timeframe. The request for external review under PRIRA must be submitted within 127 days of your receipt of the final Adverse Benefit Determination.

To request external review of an Adverse Benefit Determination pursuant to your rights under PRIRA, the Health Care Request For External Review Form must be completed and filed with the Department of Insurance and Financial Services, 530 W. Allegan St., 7th Floor, Lansing, MI 48933-1521. The Health Care Request For External Review Form is available on the DIFS website: http://www.michigan.gov/documents/cis_ofis_fis_0018_25 078_7.pdf. The request should include a copy of the final Adverse Benefit Determination, along with information and documentation to support your position. You may also file the Health Care Request For External Review Form online

at https://difs.state.mi.us/Complaints/ExternalReview.aspx.

XI. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When the Contractor advises Delta Dental to terminate your coverage.
- On the first day of the month for which the Contractor has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any Claim.
- For your Dependent, when they no longer qualify as a Dependent.
- For any other reason stated in the Contract between Delta Dental and the Contractor.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XII. Continuation of Coverage

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

1. Your employment, if applicable, ends for any reason other than your gross misconduct.
2. You do not qualify as an Enrollee as set forth in your Summary of Dental Plan Benefits.
3. You are divorced or legally separated.
4. You die.
5. Your Dependent is no longer a Dependent.
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XIII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the Covered Services that were paid for by Delta Dental,
2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co- payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a Claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will deny that portion of the Claim that Delta Dental would have paid if the Claim had been timely submitted, and such denied portion of the Claim will not be chargeable to the Member. However, you will remain responsible for any applicable Deductible and/or Copayments. In the event that a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group Contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800-524-0147